BOARD OF REGISTERED NURSING

NURSING PRACTICE COMMITTEE

AGENDA ITEM SUMMARY

AGENDA ITEM: 1.0
DATE: August 21, 2008

ACTION REQUESTED: Approve/Not Approve Minutes of May 8, 2008

REQUESTED BY: Janette Wackerly, MBA, RN
Nursing Education Consultant

BACKGROUND:

NEXT STEP: Place on Board Agenda

FISCAL IMPLICATIONS, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, MBA, RN
Nursing Education Consultant
(916) 574-7686

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF REGISTERED NURSING
P.O. Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | www.rn.ca.gov

Ruth Ann Terry, MPH, RN, Executive Officer

NURSING PRACTICE COMMITTEE MEETING DRAFT
MEETING MINUTES

DATE: May 8, 2008

TIME: 2:00 PM – 3:00 PM

LOCATION: Four Points by Sheaton
4900 Duckhorn Drive
Sacramento, CA 95834
(916) 263-9000

COMMMITTEE MEMBERS PRESENT:
Susanne J Phillips, RN, MSN, APRN-BC, FNP, Chair
Nancy L. Beecham, RNC, BS, FADONA/LTC
Carmen Morales-Board, RNC, MSN, FNPC
Elizabeth O. Dietz, EdD, RN, CS-NP

OTHERS PRESENT:
Janette Wackerly, MBA, RN NEC Liaison
Heidi Goodman, Assistant Executive Officer
Louise Bailey Med, RN SNEC
Miyo Minato, MN, RN, NEC
Badrieh Caraway, MS, RN, NEC
Katie Daugherty, MSN, RN,
La Francine Tate, Board President

Susan J Phillips, Chair, opened the meeting at 2:o0 pm with introduction of the committee

1.0 **Approve/Not Approve:** Minutes of March 20, 2008
MSC: Morales-Board/Beecham approve the minutes of March 20, 2008

2.0 Information only: Doctorate Nursing Practice: Certification Exam

The National Council of State Board of Nursing, APRN list serve notified boards of nursing about a newly-created American Board of Comprehensive Care. In order to distinguish DNP graduate who have achieved a high level of competence in comprehensive care from other APRNs, the Council for the Advancement of Comprehensive Care (CACC) and the National Board of Medical Examiners (NBME) have agreed to offer a certification examination that will validate the advanced clinical competency of a DNP program. CACC, founded in 2000, has established the American Board of Advanced Practice Nurses with national certification in an advanced nursing specialty, and a Doctor of Nursing Practice degree are eligible to sit for the examination. The exam is derived from the test pool of the USMLE Step 3 exam for MD licensure candidates. Successful DNP candidates will be designated as Diplomats in Comprehensive Care by the American Board of Comprehensive Care.

Nancy Chornick PhD. RN

Director of Practice and Credentialing, NCSBN

The American Board of Comprehensive Care (see attachment) statement is that the Council for the Advancement of Comprehensive Care and the National Board of Medical Examiners reached and agreement to develop and administer a Certification Examination for Doctors of Nursing Practice (DNP). This competency-based examination will be administered to DNP graduates for the first time in November 2008, will assess the knowledge and skills necessary to support advanced clinical practice. It will be comparable in content, similar in format and will measure the same set of competencies and apply similar performance standards as Step 3 of the United States Medical Licensing Examination (USMLE) which is administered to physician as one component of qualifying for licensure. (www.abcc.dnpcert.org/pressurerelease.shtml)

Susanne Phillips Chair reported that Columbia University, New York, Doctorate Nursing Practice, DNP, is one model whereby the graduate is expected to practice with advanced clinical competency equates to physician and the candidate for DNP is eligible to take National Board of Medical Examiner examination. The American Association of Colleges of Nursing on their website has a current listing of approximately 27 DNP programs. However, the curriculums are not patterned after the Columbia model and persons looking for a DNP program need to investigate the various types of curriculum models.

Susanne Phillips reported that advanced practice nursing, including DNP, there is a lack of consistency amongst national certifying organizations a advanced practice specialty.

3.0 Information only: Nurse Practitioner information reorganized on BRN website

DRAFT

GENERAL INFORMATION: NURSE PRACTITIONER PRACTICE

Scope of Practice

The nurse practitioner (NP) is a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to Board standards as specified in California Code of Regulations, CCR, 1484 Standards of Education.

Primary Health Care

Primary health care is defined as, that which occurs when a consumer makes contact with a health care provider, who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease CCR 1480 (b). This means that, in some cases, the NP will be the only health professional to see the patient and, in the process, will employ a combination of nursing and medical functions approved by standardized procedures.

Clinically Competent

Clinically competent means that on possess and exercises the degree of learning, skill, care ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice (CCR 1480 c)

Legal Authority for Practice

The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to perform overlapping medical functions (CCR Section 1485). Section 2725 of the Nursing Practice Act (NPA) provides authority for nursing functions that are also essential to providing primary health care which do not require standardized procedures. Examples include physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, and withdrawal of blood, as well as authority to initiate emergency procedures.

Nurse practitioners frequently ask if they really need standardized procedures. The answer is that they do when performing overlapping medical functions. Standardized procedures are the legal authority to exceed the usual scope of RN practice. Without standardized procedures the NP is legally very vulnerable, regardless of having been certified as a RN, who has acquired additional skills as a certified nurse practitioner.

Certification

Registered nurses who have been certified as NPs by the California Board of Registered Nursing may use the title nurse practitioner and place the letters “R.N., N.P.” after his/her name alone or in combination with other letters or words identifying categories of specialization, including but not limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner. (CCR 1481)

On and after January 1, 2008, an applicant will be required for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master’s degree in nursing, a master’s degree in a clinical field related to nursing,

or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. (Business and Professions Code 2835.5)

Furnishing Drugs and Devices

BPC Code Section 2836.1 authorizes NPs to obtain and utilize a "furnishing number" to furnish drugs and devices. ***Furnishing or ordering drugs and devices by the nurse practitioner is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. Furnishing is carried out according to a standardized procedure and a formulary may be incorporated. All nurse practitioners who are authorized pursuant to Section 2831.1 to furnish or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.***

BPC 2836.1 was amended changing furnishing to mean "order" for a controlled substance, and can be considered the same as an "order" initiated by the physician. This law requires the NP who has a furnishing number to obtain a DEA number to "order" controlled substances, Schedule II, III, IV, V. (AB 1545 Correa) stats 1999 ch 914 and (SB 816 Escutia) stats 1999 ch 749.

Furnishing Controlled Substances:

The furnishing or ordering of drugs and devices occurs under physician and surgeon supervision. B&P Code Section 2836.1 extends the NP, who is registered with the United States Drug Enforcement Administration, the furnishing authority or "ordering" to include Schedule II through V Controlled Substances under the Uniform Controlled Substance Act (AB 1196 Montanez) Stats2004 ch 205 § (AB 2560) There are specified educational requirements that must be met by the furnishing NP who wishes to "order" Schedule II Controlled Substances.

Drugs and/or devices furnished or "ordered" by a NP may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 commencing with Section 11000) of the Health and Safety Code and shall be further limited to those drugs agreed upon by the NP and physician and specified in the standardized procedure.

When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is to be furnished. A copy of the section for the NP's standardized procedure relating to controlled substances shall be provided upon request to any licensed pharmacist who dispenses drugs or devices when there is uncertainty about the furnishing transmittal order.

The nurse practitioner with an active furnishing number, who is authorized by standardized procedure or protocols to furnish must submit to the BRN an approved course that includes Schedule II Controlled Substances content as a part of the NP educational program or a continuing educational course with required content on Schedule II Controlled substance. The

proof of a Schedule II course received by the BRN will be noticed on the board's website, www.rn.ca.gov, in the NPF verification section.

A prescription pad may be used as transmittal order forms as long as they contain the furnisher's name and furnishing number. Pharmacy law requires the nurse practitioner name on the drug and/or device container label. The name of the supervising physician is no longer required on the drug/device container label as pharmacy law was amended BPC 1470 (f) (AB 2660 Leno) stats 2004 ch 191. The nurse practitioner DEA number is required for controlled substances. Therefore, inclusion of this information on the transmittal order form will facilitate dispensing of the drug and/or device by the pharmacist.

Dispensing Medication

Business and Professions Code Section 2725.1 allows registered nurses to dispense (hand to a patient) medication except controlled substances upon the valid order of a physician in primary, community, and free clinic.

Business and Professions Code Section 2725.1 was amended to extend to the furnishing nurse practitioner authority to dispense drugs, including controlled substances, pursuant to standardized procedures or protocols in primary, community, and free clinics. (AB 1545 Correa) stats 1999 ch 914)

Effective January 1, 2003, B&P Code Section 2836.1 Furnishing is amended to allow NPs to use their furnishing authority in solo practice per Senate Bill 933 (Figueroa) Chapter 764 signed by Governor Gray Davis on September 20, 2002.

Sign for the Request and Receipt of Pharmaceutical Samples and Devices.

Certified furnishing nurse practitioners are authorized to sign for the request and receipt of complimentary samples of dangerous drugs and devices identified in their standardized procedures or protocols that have been approved by the physician. (SB 1558 Figueroa stats 2002 ch 263) to take effect immediately. This new law amends B&P Code Section 4061 of the Pharmacy law to allow CNMs, NPs, and PAs to request and sign for complimentary samples of medication and devices.

Treating STDs

Amended into Section 120582 of the Health and Safety Code effective January 1, 2007:

(a) Not withstanding any other provision of law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, in an individual patient may prescribe, dispense, furnish, or otherwise provide a prescription antibiotic drugs to the patients sexual partner or partners without examination of that patient's partners.

(b) Not withstanding any other provision a nurse practitioner practicing pursuant to BPC Section 2836.1; a certified nurse-midwife practicing pursuant to BPC Section 2746.51; and a physician assistant pursuant to BPC 3502.1 may dispense, furnish, or otherwise provide a prescription antibiotic drug to the sexual partner or partners of a patient with a diagnosed sexually transmitted Chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services without examination of the patient's sexual partners. (AB 2280 Leno stats 2006 ch) (AB 648 Ortiz stats 2001 ch 835)

Workers' Compensation Reports

Section 3209.10 added to the labor code gives nurse practitioners the ability to cosign Doctor's First Report of Occupational Injury or illness for a worker's compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedure or protocols. The treating physician is required to sign the report and to make a determination of any temporary disability. (AB 2919 Ridley-Thomas stats 2005 extends the operation of this provision indefinitely-AB 1194 Correa stats 2001 ch 229 effective 2001)

Veterans with Disabilities Parking Placards:

Section 5007, 9105, 22511.55 of the Vehicle Code is amended to include nurse practitioners, nurse midwives and physician assistants as authorized health care professionals that can sign the certificate substantiating the applicant's disability for the placard. (AB 2120 Lui stats 2007 ch 116)

Existing law authorizes the Department of Motor Vehicles to issue placards to persons with disabilities and veteran with disabilities and temporary distinguishing placards to temporary disabled persons, to be used for parking purposes. Prior to issuing the parking placard or temporary placard, the Department of Motor Vehicles requires the submission of a certificate, signed by an authorized health care professional providing a full description substantiating the applicant's disability, unless the disability is readily observable and uncontested. Under existing law, the authorized health care professional that signs the certificate is required to retain information sufficient to substantiate the certificate, and make the information available to certain entities request of the department.

Medical Examination School Bus Drivers

Vehicle Code Section 12517.2 (a) is amended relating to schoolbus drivers driver medical examination to Applicants for an original or renewal certificate to drive a schoolbus, school pupil activity bus, youthbus, general public paratransit vehicle, or farm labor vehicle shall submit a report of medical examination of the applicant given not more than two years prior to the date of the application by a physician licensed to practice medicine , a licensed advanced practice nurse qualified to perform a medical examination, or a licensed physician assistant. The report shall be on a form approved by the department, the Federal Highway Administration, or the Federal Aviation Administration.

Schoolbus drivers, within the same month or reaching 65 years of age and each 12th month thereafter, shall undergo a medical examination, pursuant to Section 12804.9, shall submit a report of the medical examination on a form specified in subsection (a) (AB 139 Bass stats 2007, ch 158)

Informing patient: Positive and Negative aspects of Blood Transfusions

Section 1645 of the Health and Safety Code is amended to authorize the nurse practitioner and the nurse-midwife who is authorized to give blood may now provide the patient with information by means of a standardized written summary as developed or revised by the State Department of Public Health about the positive and negative aspects of receiving autologous blood and direct and nondirected homologous blood to volunteers. (SB 102 Migden stat 2007 ch 88)

Existing law requires, whenever there is reasonable possibility, as determined by a physician, that a blood transfusion may be necessary as a result of medical procedures, that the physician, by means of a standardized written summary that is published by the Medical Board and now by the Department of Public Health and distributed upon request, inform the patient of the positive and negative aspects of receiving autologous blood and directed and non directed homologous blood from volunteers.

Medi-Cal Billing: Nurse Practitioner Nationally Certified in a Specialty

Section 14132. 41 of the Welfare and Institutions Code is amended services provided by a certified nurse practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to utilization controls. The department shall permit a (nationally) certified nurse practitioner to bill Medi-Cal independently for his or her services. If a certified (nationally) nurse practitioner chooses to bill Medi-Cal independently for his or her service, the department shall make payment directly to the certified (nationally) nurse practitioner. For the purposes of this section, "certified" means nationally board certified in a recognized specialty.

Supervision

Supervision of the NP performing an overlapping medical function is addressed in the standardized procedure and may vary from one procedure to another depending upon the judgment of those developing the standardized procedure. As an example, in one women's clinic the supervision requirement for performing a cervical biopsy was that a physician must be physically present in the facility, immediately available in case of emergency. For all other standardized procedure functions, the supervision requirement was for a clinic physician to be available by phone.

The furnishing or ordering of drugs and devices by nurse practitioners occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time the patient is being examined by the nurse practitioner. For furnishing purposes, the physician may supervise a maximum of no more than four (4) NPs at one time. (BPC 2836.1)

Supervision of Medical Assistants

Nurse Practitioners and Certified Nurse-Midwives may supervise Medical Assistants in "community clinics" or "free clinics" in accord with approved standardized procedures and in accord with those supportive services the Medical Assistant is authorized to perform (Business and Professions Code, Section 2069(a)(1); and Health and Safety Code, Section 1204(a) & (b).

Citation and Fine

NPs, like all registered nurses, are subject to citation and fine for violation of the NPA. Citation and fines are a form of disciplinary action against the RN license and/or certificate. Examples of violations which have resulted in citation and fine are using the title "nurse practitioner" without being certified as a NP by the California BRN and failing to have standardized procedures when performing overlapping medical functions. NPs are encouraged to comply with all sections of the NPA to avoid discipline.

References

B&P Code, **BRN Offices** Section 2725 RN Scope of Practice, Section 2834 Nurse Practitioner, California Code of Regulation Section 1435 Citations and Fines, Section 1470 Standardized Procedure Guidelines, Section 1480 Standards for Nurse Practitioners.

Sacramento Office: (916) 322-3350
El Monte Office: (626) 575-7080

For more information, please visit the BRN's Web site at www.rn.ca.gov

4.0 Open Forum: No public participation

Submitted by: Approved by:

_____ _____
Janette Wackerly, MBA, RN Susanne J. Phillips, RN - Chair

NOTICE:
All times are approximate and subject to change. The meeting may be canceled without notice. For verification of the meeting, call 916/574-7600 or access the Board's Web Site at http://www.rn.ca.gov. Action may be taken on any item listed on this agenda, including information only items.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited.

The meeting facilities are accessible to persons with disabilities. Requests for accommodations should be made to the attention of Eleanor Calhoun at the Board of Registered Nursing, 1625 North Market Blvd., Suite N-217, Sacramento, CA, 95834 or by phone at (916) 574-7600 (Hearing impaired TDD phone number (916) 322-1700) no later than one week prior to the meeting.

CONTACT: Janette Wackerly, NEC (916) 574-7686

Nursing Practice Committee Liaison

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF REGISTERED NURSING
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Ruth Ann Terry, MPH, RN, Executive Officer

NURSING PRACTICE COMMITTEE MEETING
MEETING MINUTES

DATE: March 20, 2008

TIME: 2:00 PM – 3:00 PM

LOCATION: Hilton Los Angeles Airport
5711 West Century Blvd.
Los Angeles, CA 90045
(310) 410-4000

COMMMITTEE MEMBERS PRESENT:

Susanne J Phillips, RN, MSN, APRN-BC, FNP, Chair
Grace Corse, RN
Carmen Morales-Board, RNC, MSN, FNPC
Elizabeth O. Dietz, EdD, RN, CS-NP

OTHERS PRESENT:

Janette Wackerly, MBA, RN NEC Liaison
Ruth Ann Terry, MPH, RN Executive Officer BRN
Heidi Goodman, Assistant Executive Officer
Louise Bailey Med, RN SNEC
Maria Bedroni EdD, RN, SNEC
Miyo Minato, MN, RN, NEC
Badrieh Caraway, MS, RN, NEC
Katie Daugherty, MSN, RN,
Donna Fox RN CA Nurses Association
Geri Nibbs, MN, RN NEC
Alice Takahashi MSN, RN, NEC
La Francine Tate, Board President

Susanne J Phillips, Chair, opened the meeting at 2:10 pm with introduction of the committee

Open Forum:

Donna Dorsey Fox, CA Nurses Association Public Comment:

I would like to thank the committee of Nursing Practice, as well as the BRN Board members and BRN staff, for producing a clear regulation regarding the Administration of Insulin in Schools by unlicensed personnel.

Your clarity and ongoing work to fight this threat to the California Nursing Practice Act is consistent with the Nursing Practice Committee Goals and Objectives of 2008-2009.

Since this is the Nursing Practice Committee and not the Legislative Committee, I would like to remind everyone that your attention continues to be needed because currently this threat to the California Nursing Practice Act exists in each of the three branches of government.

Approve/Not Approve: Minutes of January 17, 2008
MSC: Dietz/Morales approve the minutes of January 17, 2008

1.0 Approve/Not Approve: Practice Committee Goals and Objectives 2008-2009

MSC: Dietz/Morales Approve the Committee Goals and Objective 2008-2009

2.0 Committee Liaison described that the only substantive change is to Goal 2, Promoting patient safety as an essential and vital component of quality nursing care.

2.1 Engage and dialog with recognized national experts in supporting patient safety in what individuals and organizations have done and what remains to be done. For example just culture and root cause analysis, failure mode and effective analysis, human factor and systems factor.

2.2 Monitor patient safety activities as a component of quality nursing care such as health care errors, competency, patient outcomes, stakeholders, nursing shortages, ethics, lifelong learning, nursing standards, licensure, safety legislation, magnet hospitals

3.0 Information Only:
(a) California HealthCare Foundation, January 2008: Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners

(b) The Center for the Health Professions, UCSF, 2007, Overview of Nurse Practitioner Scopes in the United States-Discussion.

(a) Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners.

Key Findings of the Survey:

- NPs are registered nurses with advanced clinical training. They serve as primary care providers in a broad range of acute and outpatient settings, such as pediatrics, internal medicine, anesthetics, geriatrics, and obstetrics
- NPs began to practice in the 1960's, in response to a nationwide physician shortage. Today, there are an estimated 145,000 NPs nationwide, and 13,649 in California.
- The 50 states and the District of Columbia have individual control over the laws that govern NP scope of practice. This has resulted in wide state-by-state differences in the types of services that NPs can deliver to their patients.
- These differences in scope of practice may slow the uniform expansion of NP services, prohibit NPs from providing the care for which they are trained, and hampered the use of NPs in improving access and controlling health care costs.
- California is roughly in the middle, nationwide, in NP practice autonomy and independence. NPs must collaborate with physicians and develop joint, written protocols that cover all major elements of the NP practice.
- California NPs may diagnose, order tests and durable medical equipment, refer patients, and "furnish" or "order" drugs, but only according to that protocol. There is a cap of four drug prescribing NPs per physician.
- Six states---Alaska, Arizona, New Hampshire, New Mexico, Oregon, and Washington—have NP scopes of practice that are among the nations most expansive. In these states, NPs practice autonomously, without physician oversight, and prescribe drugs without physician involvement.

The conclusion of this report:

Today there is a great deal of discussion in health policy circles, in California and across the country, of an impending physician shortage. In many ways, this current debate mirrors the events of the 1960's which spawned the initial development of the nurse practitioner.

Despite wide state-by-state differences in practice authorities, NPs deliver comprehensive medical services in a variety of settings and specialties, which are largely comparable to those provided by physicians, both in scope and medical outcomes.

The reappearance of the physician shortage issue suggests that the efficiency, accessibility, and quality of the health care system could benefit from the increased inter-professional collaboration, and be revised models for delivery of medical services that employ uniform, shared scopes of practice among providers

And with California possibly poised to overhaul its system of health care coverage, a review of the nurse practitioner's role in that system may become a part of the plan.

California Health Care Foundation, January 2008

(b) The Center for the Health Professions, UCSF. Overview of NP Scopes of Practice in the US---Discussion. Executive Summary

Nurse Practitioners (NPs) are registered nurses who are prepared beyond initial nursing education in a NP program to provide primary care directly to patients. The profession originated in the mid-1960s in response to shortage of physicians (MDs). NP education requirements, certification mechanisms and legal scopes of practice are decided at the state level and vary considerably.

NP scopes of practice vary widely among the states:

- Eleven states permit NPs to practice independently, without physician involvement
- Twenty-seven permit NPs to practice in collaboration with an MD. Collaboration definitions vary, but written practice protocols are often required
- Ten states require MD supervision of NPs
- NPs in all states may prescribe, but MD involvement is generally required to varying degrees. Additional limitations such as 72-hour or 30-day supplies may apply.
- Specific practice authorities are sometimes articulated although states may require MD involvement for any task: 44 states explicitly authorize NPs to diagnose (sometimes limited to a nursing diagnosis): 33 states explicitly authorize NPs to refer; and 20 states explicitly authorize NPs to order tests.

Education and certification requirements vary:

- Forty-two states require national certification as part of NP licensure.
- Just over half of the states require NPs to be prepared with a master's degree, while some states only require completion of a few months of post-RN education

Implications of current policy:

- Preventing professionals from practicing to the full extent of their competence negatively affects health care costs, access and quality.

- NP practices are impeded by scope of practice laws, financing and reimbursement mechanisms, malpractice insurance policies and outdated practice models.
- The professions and the public are ill-served when practice authorities differ dramatically among states.

Policy options to consider:

- Continue trend to expand NP scope of practice to match competence.
- Adopt uniform scope of practice laws to reduce variability among states
- Increase number of NP programs to reflect growing demand for primary care

UCSF Center for the Health Professions, 2007: Sharon Christian, JD, Catherine Dower, JD and Ed O'Neil, PhD, MPA, FAAN.

4.0 **Information Only**: The Center for American Nurses Calls For an End to Lateral Violence and Bullying in Nursing Work Environments – New position statement offers information and recommended strategies

Statement of Position

Lateral violence and bullying have been extensively reported and documented among healthcare professionals with serious, negative outcomes for registered nurses, their patients, and health care employers. These disruptive behaviors are toxic to the nursing profession and have a negative impact on retention of quality staff. Horizontal violence and bullying should never be considered normally related to socialization in nursing nor accepted in professional relationships. It is the position of the CENTER for American Nurses (The CENTER) that there is no place in a professional practice environment for lateral violence and bullying among nurses or between healthcare professionals. All healthcare organizations should implement a zero tolerance policy related to disruptive behavior, including a professional code of conduct and educational and behavioral interventions to assist nurses in addressing disruptive behavior. (Approved February 2008)

The CENTER in its statement defines bullying and lateral violence, as disruptive behavior, culture of safety, workplace bullying and verbal abuse.

The CENTER adopted a position statement which includes recommended strategies that nurses, employers/organizations, continuing education and academic programs and nursing researchers can employ to eliminate lateral violence and bulling.

The Center for American Nurses is a national professional nursing organization that educates, equips, and empowers nurses to advocate for themselves, their profession, and their patients. The Center offers evidence-

based solutions and powerful tools to navigate workplace challenges, optimize patient outcomes, and maximize career benefits. Established in 2003, The Center partners with its 42 organization members, comprised of over 47,000 registered nurses nationwide, to develop resources, strategies, and tools to help nurses manage evolving workforce issues and succeed in their careers. Additional information about the Center can be found at www.centerforamericannurses.org.

5.0 **Information Only**: CMS February 8, 2008: Hospitals – Revised Interpretive Guidelines for Hospital Conditions of Participation (Medicare)
The attached are the interpretive guidelines that correspond with the regulatory changes published November 27, 2006 amending Hospitals Conditions of Participation pertaining to requirements for history and physicals examination; authentication of verbal orders; securing medications; and post anesthesia evaluation.

The interpretive guidelines are important for registered nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified nurse anesthetists.

The following is a brief report and full text can be reviewed in the attachment to this agenda item.

History and Physical: § 482.22 (c) (5) (i)

Physician: Requirement for medical history and physical examination and purpose of the H&P. Medical Staff bylaws must address requirement for H&P 30 days prior to or 24 hours after hospital admission but prior to surgery or a procedure that requires anesthesia

Other qualified licensed individuals are those practitioners who are authorized in accordance with their State scope of practice laws or regulations to perform an H&P and who are formally authorized by the to conduct an H&P. Other qualified licensed practitioners could include nurse practitioners and physician assistants.

Nursing Services: § 482.54 (b) (1)

The hospital must provide nursing services 24 hours a day, 7 days a week. LPN can provide nursing services if a RN, who is immediately available for the bedside care of those patients, supervises care.

Exception: § 488.54 (c) sets forth certain conditions under which rural hospitals of 50 beds or fewer may be granted a temporary waiver of the 24 hour registered nurse requirement by the regional office.

Influenza and pneumococcal polysaccharide vaccines: § 482.23 (c) (2)

With the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accord with State law, and who is responsible for the care of the patient as specified under § 482.12 (c)

Nurse Practitioners and Physician Assistants responsible for the care of specific patients are also permitted to order drugs and biologicals in accord with delegation agreements, collaborative practice agreements, hospital policy and State law.

Note: If a hospital uses other written protocols or standing orders for drugs or biologicals that have been reviewed and approved by the medical staff, initiation of such protocol or standing orders requires an order from the practitioner responsible for patient care.

Hospitals are encourage to promote a culture in which it is not only acceptable, but also strongly encouraged, for staff to bring to the attention of the prescribing practitioner questions or concerns they have regarding orders. Any questions about the order for drugs or biologicals are expected to b e resolved prior to the preparation, or dispensing, or administration of the medication.

Verbal Orders: § 482.23 (c) (2) (i)

Verbal orders, if used, must be used infrequently. This means that the use of verbal orders must not be a common practice. Verbal orders pose an increased risk of miscommunication that could contribute to a medication or other error, resulting in a patient adverse event. Verbal orders should be used only to meet care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter the order into a computer (in case of a hospital with an electronic prescribing system) without delay of treatment. Verbal orders are not to be used for the convenience of the ordering practitioner.

Hospitals are expected to develop appropriate policies and procedures that govern the use of verbal orders and minimize their use. **CMS expects nationally accepted read-back verification practice to be implemented for every verbal order.** (71 FR 68680)

Verbal orders must be clearly communicated. All verbal orders must be immediately documented in the patient's medical record and signed by the individual receiving the order. Verbal orders should be recorded directly onto

an order sheet in the patient's medical record or entered into the computerized order entry system.

Accepting Verbal Orders: § 482.23(c) (2) (ii)

When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedure consistent with Federal and State laws.

Patient medical record entries: § 482.24 (c) (1)

All patient medical record entries must be legible, complete, dated, times and authenticated in written or electronic form by person responsible for providing or evaluating the services provided, consistent with hospital policies and procedures.

Authenticated verbal orders: § 482.9 (c) (1) (iii)

All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.

Drugs and biologicals: § 482.25 (b) (2) (i)

All drugs and biologicals must be kept in a secure area, and locked when appropriate.

(71FR 68689) This regulation gives hospitals the flexibility to integrate patient self-administration of non-controlled drugs and biologicals into their practices as appropriate.

Pre-anesthesia evaluation: § 482.51(b) (1)

The pre-anesthesia evaluation must be performed within 48 hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. At a minimum, the pre-operative anesthetic evaluation of the patient should include:

- Notation of anesthetic risk:
- Anesthetic drug and allergy history:
- Any potential anesthesia problems identified
- Patient's condition prior to induction of anesthesia

Post-anesthesia evaluation: § 482.52 (b) (3)

A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. In accordance with § 482.52 (a) anesthesia must be administered only by:

- An anesthesiologist's assistant who is under the supervision of an anesthesiologist who is immediately available if needed.

6.0 Information Only: Reorganization of Nurse Practitioner Information on BRN website

Staff Liaison requested this item be deferred until the next meeting of the committee.

Open Forum: No further public input

The Practice Committee was adjourned at 2:30 pm by Chair Susanne J. Phillips

Submitted by:

Janette Wackerly RN

Janette E. Wackerly, RN Liaison

Approved by:

Susanne J. Phillips

Susanne J. Phillips, RN, Chair

BOARD OF REGISTERED NURSING

NURSING PRACTICE COMMITTEE

AGENDA ITEM SUMMARY

AGENDA ITEM: 2.0
DATE: August 21, 2008

ACTION REQUESTED: Approve/Not approve: Consensus Model for APRN Regulation: Licensure, Accreditation, and Certification & Education

REQUESTED BY: Janette Wackerly, MBA, RN
Nursing Education Consultant

BACKGROUND:
The Consensus Model for APRN Regulation: Licensure, Accreditation, and Certification & Education were completed through the work of the APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee. Draft-APRN Joint Dialogue Group Report June 18, 2008.

The model for APRN regulation is the product of work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. These two groups were working independent of one another. However, they joined representatives of each group in what was called the APRN Joint Dialogue Group. The outcome of this work has been unanimous agreement on most of the recommendations

APRNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners. Currently, there are no uniform models of regulation for APRNs across the states. The licensing boards governed by state regulations and statutes, are the final arbitrators for who is recognized to practice within a given state. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and the certification examination accepted for entry-level competence assessment.

The Consensus Model of APRN Regulation document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialties, describes the emergence of new roles and population foci, and presents strategies for implementation.

Implementation of the recommendations for an APRN Regulatory Model will occur incrementally. Due to the interdependence of licensure, accreditation, certification and education, certain recommendations will be implemented sequentially. The document recognizes that the model was developed through consensus process with participation by APRN certifiers, accreditors, public regulators, educators, and employers, it is expected that the recommendations and model delineated will inform of decisions made by each of these entities. A target date for full implementation of the Regulatory Model and all recommendations is the Year 2015.

Information provided by:
Nancy Chornick, PhD, RN, CAE
Director of Practice and Credentialing
National Council State Boards of Nursing
nchornick@ncsbn.org

NEXT STEP: Place on Board Agenda

FISCAL IMPLICATIONS, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, MBA, RN
Nursing Education Consultant
(916) 574-7686

Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education

June 18, 2008

Completed through the work of the APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee

INTRODUCTION

Advanced Practice Registered Nurses (APRNs) have expanded in numbers and capabilities over the past several decades with APRNs being highly valued and an integral part of the health care system. Because of the importance of APRNs in caring for the current and future health needs of patients, the education, accreditation, certification and licensure of APRNs need to be effectively aligned in order to continue to ensure patient safety while expanding patient access to APRNs.

APRNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners. Each has a unique history and context, but share the commonality of being APRNs. While education, accreditation, and certification are necessary components of an overall approach to preparing an APRN for practice, the licensing boards, governed by state regulations and statutes, are the final arbiters of who is recognized to practice within a given state. Currently, there is no uniform model of regulation of APRNs across the states. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and the certification examinations accepted for entry-level competence assessment. This has created a significant barrier for APRNs to easily move from state to state and has decreased access to care for patients.

Many nurses with advanced graduate nursing preparation practice in roles and specialties, such as nurses in informatics, public health, education or administration, while essential to advance the health of the public, do not focus on direct care to individuals and, therefore, whose practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing. Like the current four APRN roles, practice in these other advanced specialty nursing roles requires specialized knowledge and skills acquired through graduate-level education. Although extremely important to the nursing profession and to the delivery of safe, high quality patient care, these other advanced, graduate nursing roles, who do not focus on direct patient care, are not Advanced Practice Registered Nurses (APRN) and are not the subject or focus of the Regulatory Model presented in this paper.

The model for APRN regulation is the product of substantial work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. While these groups began work independent of each other, they came together through representatives of each group participating in what was labeled the APRN Joint Dialogue Group. The outcome of this work has been unanimous agreement on most of the recommendations included in this document. In a few instances, when agreement was not unanimous a 66% majority was used to determine the final recommendation. However, extensive dialogue and transparency in the decision making process is reflected in each recommendation. The background of each group can be found on pages 13-16 and individual and organizational participants in each group in Appendices C-H.

This document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

Overview of APRN Model of Regulation

The APRN Model of Regulation described will be the model of the future. It is recognized that current regulation of APRNs does not reflect all of the components described in this paper and will evolve incrementally over time. A proposed timeline for implementation is presented at the end of the paper.

In this APRN model of regulation there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health. APRN education programs, including degree-granting and post-graduate education programs[1], are accredited. APRN education consists of a broad-based education, including three separate graduate-level courses in advanced physiology/pathophysiology, health assessment and pharmacology as well as appropriate clinical experiences. All developing APRN education programs or tracks go through a pre-approval, pre-accreditation or accreditation process prior to admitting students. APRN education programs must be housed within graduate programs that are nationally accredited[2] and their graduates must be eligible for national certification used for state licensure.

Individuals who have the appropriate education will sit for a certification examination to assess national competencies of the APRN core, role and at least one population focus area of practice for regulatory purposes. APRN certification programs will be accredited by a national certification accrediting body[3]. APRN certification programs will require a continued competency mechanism.

Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they can not be licensed solely within a specialty area. *In addition, specialties can provide depth in one's practice within the established population*

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[1] Degree granting programs include master's and doctoral programs. Post-graduate programs include both post-master's and post-doctoral certificate education programs.

[2] APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Division of Accreditation of the American College of Nurse-Midwives, and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

[3] The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

foci. Education and assessment strategies for specialty areas will be developed by the nursing profession, i.e. nursing organizations and special interest groups. Education for a specialty can occur concurrently with APRN education required for licensure or through post-graduate education. Competence at the specialty level will not be assessed or regulated by boards of nursing but rather by the professional organizations.

In addition, a mechanism that enhances the communication and transparency among APRN licensure, accreditation, certification and education bodies (LACE) will be developed and supported.

APRN REGULATORY MODEL

APRN Regulation includes the essential elements: licensure, accreditation, certification and education (LACE).

- Licensure is the granting of authority to practice.
- Accreditation is the formal review and approval by a recognized agency of educational degree programs in nursing or certification programs.
- Certification is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the profession.
- Education is the formal preparation of APRNs in graduate degree-granting or post-graduate certificate programs.

The APRN Regulatory Model applies to all elements of LACE. Each of these elements plays an essential part in the implementation of the model.

Definition of Advanced Practice Registered Nurse

Characteristics of the advanced practice registered nurse (APRN) were identified and several definitions of an APRN were considered, including the NCSBN and the American Nurses Association (ANA) definitions, as well as others. The characteristics identified aligned closely with these existing definitions. The definition of an APRN, delineated in this document, includes language that addresses responsibility and accountability for health promotion and the assessment, diagnosis, and management of patient problems which includes the use and prescription of pharmacologic and non-pharmacologic interventions.

The definition of an Advanced Practice Registered Nurse (APRN) is a nurse:

1. who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;
2. who has passed a national certification examination that measures APRN, role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
3. who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; however, the defining factor for **all** APRNs is that a significant component of the education and practice focuses on direct care of individuals;

4. whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
5. who is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
6. who has clinical experience of sufficient depth and breadth to reflect the intended license; **and**
7. who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

Advanced practice registered nurses are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession and the licensing board to comply with the requirements of the state nurse practice act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate.

All APRNs are educationally prepared to provide a scope of services across the health wellness-illness continuum to at least one population focus as defined by nationally-recognized role and population-focused competencies; however, the emphasis and implementation within each APRN role varies. The services or care provided by APRNs is not defined or limited by setting but rather patient care needs. The continuum encompasses the range of health states from homeostasis (or wellness) to a disruption in the state of health in which basic needs are not met or maintained (illness), with health problems of varying acuity occurring along the continuum that must be prevented or resolved to maintain wellness or an optimal level of functioning (WHO, 2006). Although all APRNs are educationally prepared to provide care to patients across the health wellness-illness continuum, the emphasis and how implemented within each APRN role varies.

The Certified Registered Nurse Anesthetist

The Certified Registered Nurse Anesthetist is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; the offices of dentists, podiatrists; ophthalmologists, and plastic surgeons.

The Certified Nurse-Midwife

The certified nurse-midwife provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth and care of the newborn. The practice includes

treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices, community and public health clinics.

The Clinical Nurse Specialist
The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, prevention of illness and risk behaviors among individuals, families, groups and communities.

The Certified Nurse Practitioner
For the certified nurse practitioner (CNP), care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing and comprehensive care that includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising and interpreting laboratory tests and Xrays, prescribing medication and durable medical equipment and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education and counseling as well as the diagnosis and management of acute and chronic diseases. Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs which have separate national consensus-based competencies and separate certification processes.

Titling

The title, Advanced Practice Registered Nurse (APRN) is the licensing title to be used for the subset of nurses prepared with advanced, graduate-level nursing knowledge to provide direct patient care in four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner.[4] This title, APRN, is a legally

[4] Nurses with advanced graduate nursing preparation practicing in roles and specialties that do not provide direct care to individuals and, therefore, whose practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing may not use any term or title which may confuse the public, including advanced practice nurse or advanced practice registered nurse. The term, advanced public health nursing, however, may be used to identify nurses practicing in this advanced specialty area of nursing.

protected title. Licensure and scope of practice are based on graduate education in one of the four roles and in a defined population.

Verification of licensure, whether hard copy or electronic, will indicate the role and population for which the APRN has been licensed.

At a minimum, an individual must legally represent themselves, including in a legal signature, as an APRN and by the role. He/she may indicate the population as well. No one, except those who are licensed to practice as an APRN, may use the APRN title or any of the APRN role titles.

An individual also may add the specialty title in which they are professionally recognized in addition to the legal title of APRN and role.

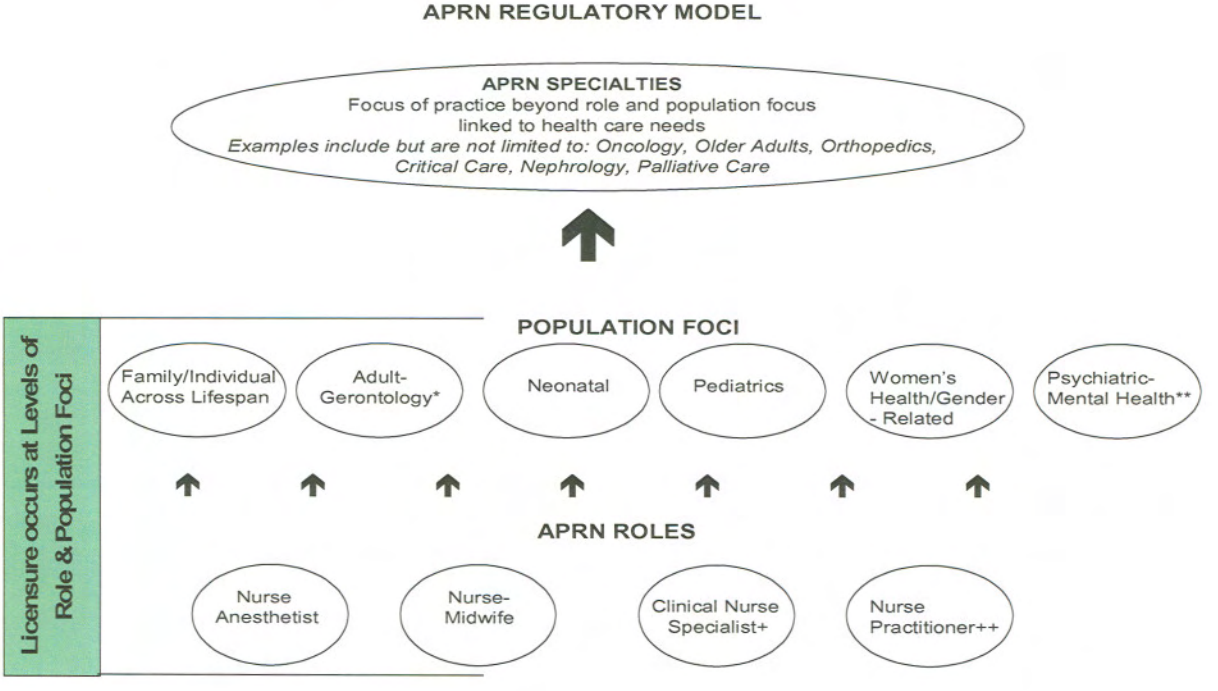


Diagram 1: APRN Regulatory Model
Under this APRN Regulatory Model, there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender-related or psych/mental health. Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they can not be licensed solely within a specialty area. Specialties can provide depth in one's practice within the established population foci.

* The population focus, adult-gerontology, encompasses the young adult to the older adult, including the frail elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population, e.g. family or gender specific, must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

** The population focus, psychiatric/mental health, encompasses education and practice across the lifespan.

+ The Clinical Nurse Specialist (CNS) is educated and assessed through national certification processes across the continuum from wellness through acute care.

++The certified nurse practitioner (CNP) is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is **not setting specific** but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles.

Broad-based APRN Education

For entry into APRN practice and for regulatory purposes, APRN education must:

- be formal education with a graduate degree or post-graduate certificate (either post-master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA);
- be awarded pre-approval, pre-accreditation or accreditation status prior to admitting students;
- be comprehensive and at the graduate level;
- prepare the graduate to practice in one of the four identified APRN roles;
- prepare the graduate with the core competencies for one of the APRN roles across *at least one* of the six population foci;
- include at a minimum, three separate comprehensive ***graduate-level*** courses (the APRN Core) in:
    - Advanced physiology/pathophysiology, including general principles that apply across the lifespan;
    - Advanced health assessment which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and
    - Advanced pharmacology which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.
- Additional content, specific to the role and population, in these three APRN core areas should be integrated throughout the other role and population didactic and clinical courses;
- Provide a basic understanding of the principles for decision making in the identified role;

- Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems which includes the use and prescription of pharmacologic and non-pharmacologic interventions; and
- Ensure clinical and didactic coursework is comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

Preparation in a specialty area of practice is optional but if included must build on the APRN role/population-focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus.

As part of the accreditation process, all APRN education programs must undergo a pre-approval, pre-accreditation or accreditation process prior to admitting students. The purpose of the pre-approval process is twofold: 1) to ensure that students graduating from the program will be able to meet the education criteria necessary for national certification in the role and population-focus and if successfully certified, are eligible for licensure to practice in the APRN role/population-focus; and 2) to assure that programs will meet all educational standards prior to starting the program. The pre-approval, pre-accreditation or accreditation processes may vary across APRN roles.

APRN Specialties

Preparation in a specialty area of practice is optional, but if included must build on the APRN role/population-focused competencies. Specialty practice represents a much more focused area of preparation and practice than does the APRN role/population focus level. Specialty practice may focus on specific patient populations beyond those identified or health care needs such as oncology, palliative care, substance abuse or nephrology. The criteria for defining an APRN specialty is built upon the ANA (2004) Criteria for Recognition as a Nursing Specialty (see Appendix B). APRN specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus. For example, a family CNP could specialize in elder care or nephrology; an Adult-Gerontology CNS could specialize in palliative care; a CRNA could specialize in pain management; or a CNM could specialize in care of the post-menopausal woman. State licensing boards will not regulate the APRN at the level of specialties in this APRN Regulatory Model. Professional certification in the specialty area of practice is strongly recommended.

An APRN specialty

- preparation can not replace educational preparation in the role or one of the six population foci;
- preparation can not expand one's scope of practice beyond the role or population focus
- addresses a subset of the population-focus;
- title may not be used in lieu of the licensing title which includes the role or role/population; and
- is developed, recognized and monitored by the profession.

New specialties emerge based on health needs of the population. APRN specialties develop to provide added value to the role practice as well as providing flexibility within the profession to meet these emerging needs of patients. Specialties also may cross several or all APRN roles. A specialty evolves out of an APRN role/population focus and indicates that an APRN has *additional* knowledge and expertise in a more discrete area of specialty practice. Competency in the specialty areas could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms, such as portfolios, examinations, etc.

Education programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN education programs, including preparation in the APRN core, role and population core competencies. In addition, for licensure purposes, one exam must assess the APRN core, role and population-focused competencies. For example, a nurse anesthetist would write one certification examination, which tests the APRN core, CRNA role and population-focused competencies, administered by the Council on Certification for Nurse Anesthetist; or a primary care family nurse practitioner would write one certification examination, which tests the APRN core, CNP role and family population-focused competencies, administered by ANCC or AANP. Specialty competencies must be assessed separately. In summary, education programs preparing individuals with this additional knowledge in a specialty, *if used for entry into advanced practice registered nursing and for regulatory purposes*, must also prepare individuals in one of the four nationally recognized APRN roles and in one of the six population foci. Individuals must be recognized and credentialed in one of the four APRN roles within at least one population foci. APRNs are licensed at the role/population focus level and **not** at the specialty level. However, if not intended for entry-level preparation in one of the four roles/population foci and not for regulatory purposes, education programs, using a variety of formats and methodologies, may provide licensed APRNs with the additional knowledge, skills and abilities, to become professionally certified in the specialty area of APRN practice.

Emergence of New APRN Roles and Population-Foci

As nursing practice evolves and health care needs of the population change, new APRN roles or population-foci may evolve over time. An APRN role would encompass a unique or significantly differentiated set of competencies from any of the other APRN roles. In addition, the scope of practice within the role or population focus is not entirely subsumed within one of the other roles. Careful consideration of new APRN roles or population-foci is in the best interest of the profession.

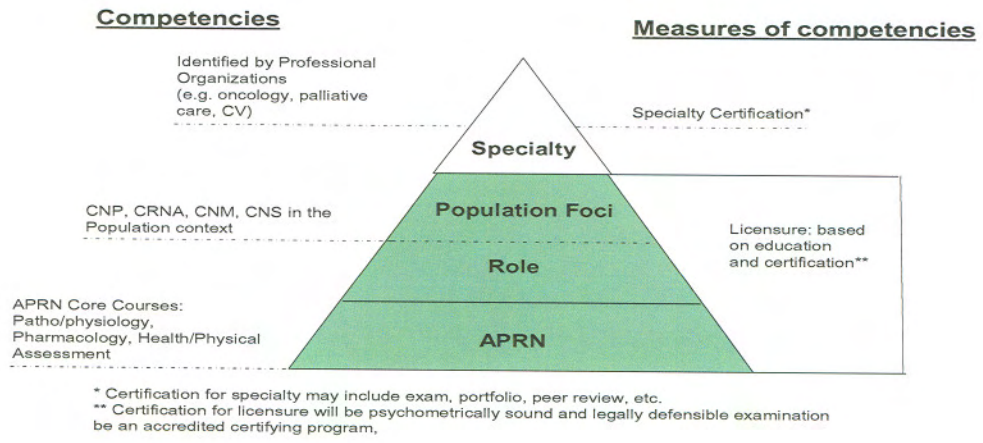
For licensure, there must be clear guidance for national recognition of a new APRN role or population-focus. A new role or population focus should be discussed and vetted through the national licensure, accreditation, certification, education communication structure, LACE. An essential part of being recognized as a role or population-focus is that educational standards and practice competencies must exist, be consistent, and must be nationally recognized by the profession. Characteristics of the process to be used to develop nationally

recognized core competencies, and education and practice standards for a newly emerging role or population-focus are:

1. National in scope
2. Inclusive
3. Transparent
4. Accountable
5. Initiated by nursing
6. Consistent with national standards for licensure, accreditation, certification and education
7. Evidence-based
8. Consistent with regulatory principles.

To be recognized, an APRN role must meet the following criteria:

- Nationally recognized education standards and core competencies for programs preparing individuals in the role;
- Education programs, including graduate degree granting (master's, doctoral) and post-graduate certificate programs, are accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA); and
- Professional nursing certification program which is psychometrically sound, legally defensible and which meets nationally recognized accreditation standards for certification programs.[5]



[5] The professional certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

Diagram 2: Relationship Among Educational Competencies, Licensure, & Certification in the Role/Population Foci and Education and Credentialing in a Specialty

IMPLEMENTATION STRATEGIES FOR APRN REGULATORY MODEL

In order to accomplish the above model, the four prongs of regulation: licensure, accreditation, certification and education (LACE) must work together. Expectations for licensure, accreditation, certification, and education are listed below:

Foundational Requirements for Licensure

Boards of nursing will:

1. license APRNs in the categories of Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Clinical Nurse Specialist or Certified Nurse Practitioner within a specific population focus;
2. be solely responsible for licensing Advanced Practice Registered Nurses[6];
3. only license graduates of accredited graduate programs that prepare graduates with the APRN core, role and population competencies;
4. require successful completion of a national certification examination that assesses APRN core, role and population competencies for APRN licensure.
5. not issue a temporary license;
6. only license an APRN when education and certification are congruent;
7. license APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision;
8. allow for mutual recognition of advanced practice registered nursing through the APRN Compact;
9. have at least one APRN representative position on the board and utilize an APRN advisory committee which includes representatives of all four APRN roles; and,
10. institute a grandfathering[7] clause which will exempt those APRNs already practicing in the state from new eligibility requirements.

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[6] Except in states where state boards of nurse-midwifery or midwifery regulate nurse-midwives or nurse-midwives and midwives jointly.

[7] Grandfathering is a provision in a new law exempting those already in or a part of the existing system that is being regulated. When states adopt new eligibility requirements for APRNs, currently practicing APRNs will be permitted to continue practicing within the state(s) of their current licensure.
However, if an APRN applies for licensure by endorsement in another state, the APRN would be eligible for licensure if s/he demonstrates that the following criteria have been met:

- current, active practice in the advanced role and population focus area,
- current active, national certification or recertification, as applicable, in the advanced role and population focus area,
- compliance with the APRN educational requirements of the state in which the APRN is applying for licensure that were in effect at the time the APRN completed his/her APRN education program, and
- compliance with all other criteria set forth by the state in which the APRN is applying for licensure (e.g. recent CE, RN licensure).

Once the model has been adopted and implemented (date to be determined by the state boards of nursing. See proposed timeline on page 14-15.) all new graduates applying for APRN licensure must meet the requirements outlined in this regulatory model

Foundational Requirements for Accreditation of Education Programs

Accreditors will:

1. be responsible for evaluating APRN education programs including graduate degree-granting and post-graduate certificate programs.[8].
2. through their established accreditation standards and process, assess APRN education programs in light of the APRN core, role core, and population core competencies;
3. assess developing APRN education programs and tracks by reviewing them using established accreditation standards and granting pre-approval, pre-accreditation or accreditation prior to student enrollment;
4. include an APRN on the visiting team when an APRN program/track is being reviewed; and
5. monitor APRN educational programs throughout the accreditation period by reviewing them using established accreditation standards and processes.

Foundational Requirements for Certification

Certification programs providing APRN certification used for licensure will:

1. follow established certification testing and psychometrically sound, legally defensible standards for APRN examinations for licensure. (see appendix A for the NCSBN Criteria for APRN Certification Programs);
2. assess the APRN core and role competencies across at least one population focus of practice;
3. certification used for regulatory purposes must demonstrate in the test blueprint that the APRN, role and population-focused competencies are assessed
4. delineate separately from the APRN core, role and population-focused competencies in the test blue print, if specialty content is tested in the same examination, what specialty competencies are tested
5. be accredited by a national certification accreditation body;[9]
6. enforce congruence (role and population focus) between the education program and the type of certification examination;
7. provide a mechanism to ensure ongoing competence and maintenance of certification;
8. participate in ongoing relationships which make their processes transparent to boards of nursing;
9. participate in a mutually agreeable mechanism to ensure communication with boards of nursing and schools of nursing.

Foundational Requirements for Education

APRN education programs/tracks leading to APRN licensure, including graduate degree-granting and post-graduate certificate programs will:

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[8] Degree-granting programs include both master's and doctoral programs. Post-graduate certificate programs include post-master's and post-doctoral education programs.

[9] The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

1. follow established educational standards and ensure attainment of the APRN core, role core and population core competencies[10,11]
2. be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA). [12]
3. be pre-approved, pre-accredited or accredited prior to the acceptance of students, including all developing APRN education programs and tracks;
4. ensure that graduates of the program are eligible for national certification and state licensure; and
5. ensure that official documentation (e.g. transcript) specifies the role and population focus of the graduate.

Communication Strategies

A formal communication mechanism, LACE, which includes those regulatory organizations that represent APRN licensure, accreditation, certification, and education entities would be created. The purpose of LACE would be to provide a formal, ongoing communication mechanism that provides for transparent and aligned communication among the identified entities. The collaborative efforts between the APRN Consensus Group and the NCSBN APRN Advisory Panel, through the APRN Joint Dialogue Group have illustrated the ongoing level of communication necessary among these groups to ensure that all APRN stakeholders are involved. Several strategies including equal representation on an integrated board with face-to-face meetings, audio and webcast conferencing, pass protected access to agency websites, and regular reporting mechanisms have been recommended. These strategies will build trust and enhance information sharing. Examples of issues to be addressed by the group would be: guaranteeing appropriate representation of APRN roles among accreditation site visitors, documentation of program completion by education institutions, notification of examination outcomes to educators and regulators, notification of disciplinary action toward licensees by boards of nursing.

Creating the LACE Structure and Processes

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[10] The APRN core competencies for all APRN nursing education programs located in schools of nursing are delineated in the American Association of Colleges of Nursing (1996) *The Essentials of Master's Education for Advanced Practice Nursing Education* or the AACN (2006) *The Essentials of Doctoral Education for Advanced Nursing Practice*. The APRN core competencies for nurse anesthesia and nurse-midwifery education programs located outside of a school of nursing are delineated by the accrediting organizations for their respective roles i.e., Council on Accreditation of Nurse Anesthesia Educational Programs (COA), American College of Nurse-Midwives Division of Accreditation (ACNMDOA).

[11] APRN programs outside of schools of nursing must prepare graduates with the APRN core which includes three separate graduate-level courses in pathophysiology/physiology, health assessment, and pharmacology.

[12] APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Division of Accreditation of the American College of Nurse-Midwives, and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

Several principles should guide the formulation of a structure including: 1) all four entities of LACE should have representation; 2) the total should allow effective discussion of and response to issues and ; 3) the structure should not be duplicative of existing structures such as the Alliance for APRN Credentialing. Consideration should be given to evolving the existing Alliance structure to meet the needs of LACE. Guidance from an organizational consultant will be useful in forming a permanent structure that will endure and support the work that needs to continue. The new structure will support fair decision-making among all relevant stakeholders. In addition, the new structure will be in place as soon as possible.

The LACE organizational structure should include representation of:

- State licensing boards, including at least one compact and one non-compact state;
- Accrediting bodies that accredit education programs of the four APRN roles;
- Certifying bodies that offer APRN certification used for regulatory purposes; and,
- Education organizations that set standards for APRN education.

Timeline for Implementation of Regulatory Model

Implementation of the recommendations for an APRN Regulatory Model will occur incrementally. Due to the interdependence of licensure, accreditation, certification and education, certain recommendations will be implemented sequentially. However, recognizing that this model was developed through a consensus process with participation of APRN certifiers, accreditors, public regulators, educators, and employers, it is expected that the recommendations and model delineated will inform decisions made by each of these entities as the APRN community moves to fully implement the APRN Regulatory Model. A target date for full implementation of the Regulatory Model and all embedded recommendations is the Year 2015.

HISTORICAL BACKGROUND

NCSBN APRN Committee (previously APRN Advisory Panel)

NCSBN became involved with advanced practice nursing when boards of nursing began using the results of APRN certification examinations as one of the requirements for APRN licensure. During the 1993 NCSBN annual meeting, delegates adopted a position paper on the licensure of advanced nursing practice which included model legislation language and model administrative rules for advanced nursing practice. NCSBN core competencies for certified nurse practitioners were adopted the following year.

In 1995, NCSBN was directed by the Delegate Assembly to work with APRN certifiers to make certification examinations suitable for regulatory purposes. Since then, much effort has been made toward that purpose. During the mid and late 90's, the APRN certifiers agreed to undergo accreditation and provide additional information to boards of nursing to ensure that their examinations were psychometrically sound and legally defensible. (NCSBN, 1998)

During the early 2000's, the APRN Advisory Panel developed criteria for ARPN certification programs and for accreditations agencies. In January 2002, the Board of Directors approved

the criteria and process for a new review process for APRN certification programs. The criteria represented required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses. Subsequently, the APRN Advisory Panel has worked with certification programs to improve the legal defensibility of APRN certification examinations and to promote communication with all APRN stakeholders regarding APRN regulatory issues such as with the establishment of the annual NCSBN APRN Roundtable in the mid 1990's. In 2002, the Advisory Panel also developed a position paper describing APRN regulatory issues of concern.

In 2003, the APRN Advisory Panel began a draft APRN Vision Paper in an attempt to resolve APRN regulatory concerns such as the proliferation of APRN subspecialty areas. The purpose of the APRN Vision Paper was to provide direction to boards of nursing regarding APRN regulation for the next eight to ten years by identifying an ideal future APRN regulatory model. Eight recommendations were made. The draft vision paper was completed in 2006. After reviewing the draft APRN Vision Paper at their February 2006 board meeting, the board of directors directed that the paper be disseminated to boards of nursing and APRN stakeholders for feedback. The Vision paper also was discussed during the 2006 APRN Roundtable. The large response from boards of nursing and APRN stakeholders was varied. The APRN Advisory Panel spent the remaining part of 2006, reviewing and discussing the feedback with APRN stakeholders. (See Appendix C for the list of APRN Advisory Panel members who worked on the draft APRN Vision Paper and Appendix D for the list of organizations represented at the 2006 APRN Roundtable where the draft Vision Paper was presented.)

APRN Consensus Group

In March 2004, the American Association of Colleges of Nursing (AACN) and the National Organization of Nurse Practitioner Faculties (NONPF) submitted a proposal to the Alliance for Nursing Accreditation, now named Alliance for APRN Credentialing[13] (hereafter referred to as "the APRN Alliance") to establish a process to develop a consensus[14] statement on the credentialing of advanced practice nurses (APNs).[15] The APRN Alliance[16], created in 1997,

[13] At its March 2006 meeting, the Alliance for Nursing Accreditation voted to change its name to the Alliance for APRN Credentialing which more accurately reflects its membership.

[14] The goal of the APRN Work Group was unanimous agreement on all issues and recommendations. However, this was recognized as an unrealistic expectation and may delay the process; therefore, consensus was defined as a two thirds majority agreement by those members of the Work Group present at the table as organizational representatives with each participating organization having one vote.

[15] The term advanced practice nurse (APN) was initially used by the Work Group and is used in this section of the report to accurately reflect the background discussion. However, the Work group reached consensus that the term advanced practice registered nurse (APRN) should be adopted for use in subsequent discussions and documents.

[16] Organizational members of the Alliance for APRN Credentialing : American Academy of Nurse Practitioners Certification Program, American Association of Colleges of Nursing, American Association of Critical-Care Nurses Certification Corporation, Council on Accreditation of Nurse Anesthesia Educational Programs, American College of Nurse-Midwives, American Nurses Credentialing Center, Association of Faculties of Pediatric Nurse Practitioners, Inc., Commission on Collegiate Nursing Education, National Association of Clinical Nurse Specialists, National Association of Nurse Practitioners in Women's Health, Council on Accreditation, Pediatric Nursing Certification Board, The National Certification Corporation for the Obstetric

was convened by AACN to regularly discuss issues related to nursing education, practice, and credentialing. A number of differing views on how APN practice is defined, what constitutes specialization versus subspecialization, and the appropriate credentialing requirements that would authorize practice had emerged over the past several years.

An invitation to participate in a national APN Consensus Process was sent to 50 organizations that were identified as having an interest in advanced practice nursing (see Appendix E). Thirty-two organizations participated in the APN Consensus Conference in Washington, DC June 2004 (See Appendix F). The focus of the one-day meeting was to initiate an in-depth examination of issues related to APN definition, specialization, sub-specialization, and regulation, which includes accreditation, education, certification and licensure[17]. Based on recommendations generated in the June 2004 APN Consensus Conference, the Alliance formed a smaller work group made up of designees from 23 organizations with broad representation of APN certification, licensure, education, accreditation, and practice. The charge to the work group was to develop a statement that addresses the issues, delineated during the APN Consensus Conference with the goal of envisioning a future model for APNs. The Alliance APN Consensus Work Group (hereafter referred to as "the Work Group") convened for sixteen days of intensive discussion between October 2004 and July 2007. (See Appendix G for a list of organizations represented on the APN Work Group.)

In December 2004, the American Nurses Association (ANA) and the American Association of Colleges of Nursing (AACN) co-hosted an APN stakeholder meeting to address those issues identified at the June 2004 APN Consensus meeting. Attendees agreed to ask the APN Work Group to continue to craft a consensus statement that would include recommendations regarding APN regulation, specialization and subspecialization. It also was agreed that organizations in attendance who had not participated in the June 2004 APN Consensus meeting would be included in the APN Consensus Group and that this larger group would reconvene at a future date to discuss the recommendations of the APN Work Group.

Following the December 2004 APN Consensus meeting, the Work Group continued to work diligently to reach consensus on the issues surrounding APRN education, practice, accreditation, certification and licensure, and to create a future consensus-based model for APRN regulation. Subsequent APRN Consensus Group meetings were held in September 2005, and June 2006. All organizations who participated in the APRN Consensus Group are listed in Appendix H.

APRN Joint Dialogue Group

In April, 2006, the APRN Advisory Panel met with the APRN Consensus Work Group to discuss APRN issues described in the NCSBN draft Vision Paper. The APRN Consensus

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Gynecologic and Neonatal Nursing Specialties, National Council of State Boards of Nursing, National Organization of Nurse Practitioner Faculties

[17] The term regulation refers to the four prongs of regulation: licensure, accreditation, certification and education.

Work Group requested and was provided with feedback from the APRN Advisory Panel regarding the APRN Consensus Group Report. Both groups agreed to continue to dialogue.

As the APRN Advisory Panel and APRN Consensus Work Group continued their work in parallel fashion, concerns regarding the need for each group's work not to conflict with the other were expressed. A subgroup of seven people from the APRN Consensus Work Group and seven individuals from the APRN Advisory Panel were convened in January, 2007. The group called itself the APRN Joint Dialogue Group (see Appendix E) and the agenda consisted of discussing areas of agreement and disagreement between the two groups. The goal of the subgroup meetings was anticipated to be two papers that did not conflict, but rather complemented each other. However, as the APRN Joint Dialogue Group continued to meet, much progress was made regarding areas of agreement; it was determined that rather than two papers being disseminated, one joint paper would be developed which reflected the work of both groups. This document is the product of the work of the APRN Joint Dialogue Group and through the consensus-based work of the APRN Consensus Work Group and the NCSBN APRN Advisory Committee.

Assumptions Underlying the Work of the Joint Dialogue Group

The consensus-based recommendations that have emerged from the extensive dialogue and consensus-based processes delineated in this report are based on the following assumptions:

- Recommendations must address current issues facing the advanced practice registered nurse (APRN) community but should be future oriented.
- The ultimate goal of licensure, accreditation, certification and education is to promote patient safety and public protection.
- The recognition that this document was developed with the participation of APRN certifiers, accreditors, public regulators, educators, and employers. The intention is that the document will allow for informed decisions made by each of these entities as they address APRN issues.

CONCLUSION

The recommendations offered in this paper present an APRN regulatory model as a collaborative effort among APRN educators, accreditors, certifiers and licensure bodies. The essential elements of APRN regulation are identified as licensure, accreditation, certification and education. The recommendations reflect a need and desire to collaborate among regulatory bodies to achieve a sound model and continued communication with the goal of increasing the clarity and uniformity of APRN regulation.

The goals of the consensus processes were to:

- Strive for harmony and common understanding in the APRN regulatory community that would continue to promote quality APRN education and practice;
- Develop a vision for APRN regulation, including education, accreditation, certification and licensure;
- Establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care; and

- Produce a written statement that reflects consensus on APRN regulatory issues.

In summary, this report defines the APRN Regulatory Model, including a definition of the Advanced Practice Registered Nurse; a definition of broad-based APRN education; a model for regulation that ensures APRN education and certification as a valid and reliable process, that is based on nationally recognized and accepted standards; uniform recommendations for licensing bodies across states; a process and characteristics for recognizing a new APRN role; and a definition of an APRN specialty that allows for the profession to meet future patient and nursing needs.

The work of the Joint Dialogue Group in conjunction with all organizations representing APRN licensure, accreditation, certification and education to advance a regulatory model is an ongoing collaborative process that is fluid and dynamic. As health care evolves and new standards and needs emerge the APRN Regulatory Model will advance accordingly to allow APRNs to care for patients in a safe environment to the full potential of their nursing knowledge and skill.

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APPENDIX A
NCSBN CRITERIA FOR EVALUATING CERTIFICATION PROGRAMS

Criteria	Elaboration
I. The program is national in the scope of its credentialing.	A. The advanced nursing practice category and standards of practice have been identified by national organizations. B. Credentialing services are available to nurses throughout the United States and its territories. C. There is a provision for public representation on the certification board. D. A nursing specialty organization that establishes standards for the nursing specialty exists. E. A tested body of knowledge related to the advanced practice nursing specialty exists. F. The certification board is an entity with organizational autonomy.
II. Conditions for taking the examination are consistent with acceptable standards of the testing community.	A. Applicants do not have to belong to an affiliated professional organization in order to apply for certification offered by the certification program. B. Eligibility criteria rationally related to competence to practice safely. C. Published criteria are enforced. D. In compliance with the American Disabilities Act. E. Sample application(s) are available. 1) Certification requirements included 2) Application procedures include: • procedures for assuring match between education and clinical experience, and APRN specialty being certified, • procedures for validating information provided by candidate, • procedures for handling omissions and discrepancies 3) Professional staff responsible for credential review and admission decisions. 4) Examination should be administered frequently enough to be accessible but not so frequently as to over-expose items. F. Periodic review of eligibility criteria and application procedures to ensure that they are fair and equitable.
III. Educational requirements are consistent with the requirements of the advanced practice specialty.	A. Current U.S. registered nurse licensure is required. B. Graduation from a graduate advanced practice education program meets the following requirements: 1) Education program offered by an accredited college or university offers a graduate degree with a concentration in the advanced nursing practice specialty the individual is seeking 2) If post-masters certificate programs are offered, they must be offered through institutions meeting criteria B.1.

	3) Both direct and indirect clinical supervision must be congruent with current national specialty organizations and nursing accreditation guidelines 4) The curriculum includes, but is not limited to: • biological, behavioral, medical and nursing sciences relevant to practice as an APRN in the specified category; • legal, ethical and professional responsibilities of the APRN; and • supervised clinical practice relevant to the specialty of APRN 5) The curriculum meets the following criteria: • Curriculum is consistent with competencies of the specific areas of practice • Instructional track/major has a minimum of 500 supervised clinical hours overall • The supervised clinical experience is directly related to the knowledge and role of the specialty and category C. All individuals, without exception, seeking a national certification must complete a formal didactic and clinical advanced practice program meeting the above criteria.
IV. The standard methodologies used are acceptable to the testing community such as incumbent job analysis study, logical job analysis studies.	A. Exam content based on a job/task analysis. B. Job analysis studies are conducted at least every five years. C. The results of the job analysis study are published and available to the public. D. There is evidence of the content validity of the job analysis study.
V. The examination represents entry-level practice in the advanced nursing practice category.	A. Entry-level practice in the advanced practice specialty is described including the following: 1) Process 2) Frequency 3) Qualifications of the group making the determination 4) Geographic representation 5) Professional or regulatory organizations involved in the reviews
VI. The examination represents the knowledge, skills and abilities essential for the delivery of safe and effective advanced nursing care to the clients.	A. The job analysis includes activities representing knowledge, skills and abilities necessary for competent performance. B. The examination reflects the results of the job analysis study. C. Knowledge, skills and abilities, which are critical to public safety, are identified. D. The examination content is oriented to educational curriculum practice requirements and accepted standards of care.
VII. Examination items are reviewed for content validity, cultural bias and correct scoring using an established mechanism, both before use and	A. Each item is associated with a single cell of the test plan. B. Items are reviewed for currency before each use at least every three years. C. Items are reviewed by members of under-represented gender and

periodically.	ethnicities who are active in the field being certified. Reviewers have been trained to distinguish irrelevant cultural dependencies from knowledge necessary to safe and effective practice. Process for identifying and processing flagged items is identified. D. A statistical bias analysis is performed on all items. E. All items are subjected to an "unscored" use for data collection purposes before their first use as a "scored" item. F. A process to detect and eliminate bias from the test is in place. G. Reuse guidelines for items on an exam form are identified. H. Item writing and review is done by qualified individuals who represent specialties, population subgroups, etc.
VIII. Examinations are evaluated for psychometric performance.	A. Reference groups used for comparative analysis are defined.
IX. The passing standard is established using acceptable psychometric methods, and is re-evaluated periodically.	A. Passing standard is criterion-referenced.
X. Examination security is maintained through established procedures.	A. Protocols are established to maintain security related to: 1) Item development (e.g., item writers and confidentiality, how often items are re-used) 2) Maintenance of question pool 3) Printing and production process 4) Storage and transportation of examination is secure 5) Administration of examination (e.g., who administers, who checks administrators) 6) Ancillary materials (e.g., test keys, scrap materials) 7) Scoring of examination 8) Occurrence of a crisis (e.g., exam is compromised, etc)
XI. Certification is issued based upon passing the examination and meeting all other certification requirements.	A. Certification process is described, including the following: 1) Criteria for certification decisions are identified 2) The verification that passing exam results and all other requirements are met 3) Procedures are in place for appealing decisions B. There is due process for situations such as nurses denied access to the examination or nurses who have had their certification revoked. C. A mechanism is in place for communicating with candidate. D. Confidentiality of nonpublic candidate data is maintained.
XII. A retake policy is in place.	A. Failing candidates permitted to be reexamined at a future date. B. Failing candidates informed of procedures for retakes. C. Test for repeating examinees should be equivalent to the test for first time candidates. D. Repeating examinees should be expected to meet the same test performance standards as first time examinees.

	E. Failing candidates are given information on content areas of deficiency. F. Repeating examinees are not exposed to the same items when taking the exam previously.
XIII. Certification maintenance program, which includes review of qualifications and continued competence, is in place.	A. Certification maintenance requirements are specified (e.g., continuing education, practice, examination, etc.). B. Certification maintenance procedures include: 1) Procedures for assuring match between continued competency measures and APRN specialty 2) Procedures for validating information provided by candidates 3) Procedures for issuing re-certification C. Professional staff oversee credential review. D. Certification maintenance is required a minimum of every 5 years.
XIV. Mechanisms are in place for communication to boards of nursing for timely verification of an individual's certification status, changes in certification status, and changes in the certification program, including qualifications, test plan and scope of practice.	A. Communication mechanisms address: 1) Permission obtained from candidates to share information regarding the certification process 2) Procedures to provide verification of certification to Boards of Nursing 3) Procedures for notifying Boards of Nursing regarding changes of certification status 4) Procedures for notification of changes in certification programs (qualifications, test plan or scope of practice) to Boards of Nursing
XV. An evaluation process is in place to provide quality assurance in its certification program.	A. Internal review panels are used to establish quality assurance procedures. 1) Composition of these groups (by title or area of expertise) is described 2) Procedures are reviewed 3) Frequency of review B. Procedures are in place to insure adherence to established QA policy and procedures.

Revised 11-6-01

APPENDIX B

American Nurses Association
Congress on Nursing Practice and Economics
2004

Recognition as a Nursing Specialty

The process of recognizing an area of practice as a nursing specialty allows the profession to formally identify subset areas of focused practice. A clear description of that nursing practice assists the larger community of nurses, healthcare consumers, and others to gain familiarity and understanding of the nursing specialty. Therefore, the document requesting ANA recognition must clearly and fully address each of the fourteen specialty recognition criteria. The inclusion of additional materials to support the discussion and promote understanding of the criteria is acceptable. A scope of practice statement must accompany the submission requesting recognition as a nursing specialty.

Criteria for Recognition as a Nursing Specialty

The following criteria are used by the Congress on Nursing Practice and Economics in the review and decision-making processes to recognize an area of practice as a nursing specialty:

A nursing specialty:

1. Defines itself as nursing.
2. Adheres to the overall licensure requirements of the profession.
3. Subscribes to the overall purposes and functions of nursing.
4. Is clearly defined.
5. Is practiced nationally or internationally.
6. Includes a substantial number of nurses who devote most of their practice to the specialty.
7. Can identify a need and demand for itself.
8. Has a well derived knowledge base particular to the practice of the nursing specialty.
9. Is concerned with phenomena of the discipline of nursing.
10. Defines competencies for the area of nursing specialty practice.
11. Has existing mechanisms for supporting, reviewing and disseminating research to support its knowledge base.

12. Has defined educational criteria for specialty preparation or graduate degree.

13. Has continuing education programs or continuing competence mechanisms for nurses in the specialty.

14. Is organized and represented by a national specialty association or branch of a parent organization.

APPENDIX C

NCBN APRN Committee Members 2003 -2008

2003

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Kim Powell, Board President, Montana Board of Nursing
- Charlene Hanson, Consultant
- Georgia Manning, Arkansas State Board of Nursing
- Deborah Bohannon-Johnson, Board President, North Dakota Board of Nursing
- Jane Garvin, Board President, Maryland Board of Nursing
- Janet Younger, Board President, Virginia Board of Nursing
- Nancy Chornick, NCSBN

2004

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Kim Powell, Board President, Montana Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Laura Poe, Member Utah State Board of Nursing
- Georgia Manning, Arkansas State Board of Nursing
- Jane Garvin RN, Board President, Maryland Board of Nursing
- Ann Forbes, Member Board Staff, North Carolina Board of Nursing
- Nancy Chornick, NCSBN

2005

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Laura Poe, Member Utah State Board of Nursing
- Marcia Hobbs, Member Board Member, Kentucky Board of Nursing
- Randall Hudspeth, Member Board Member, Idaho Board of Nursing
- Ann Forbes, Member Board Staff, North Carolina Board of Nursing
- Cristiana Rosa, Member Board Member, Rhode Island Board of Nurse
- Kim Powell, Board President, Montana Board of Nursing
- Nancy Chornick, NCSBN

2006

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Laura Poe, Member Utah State Board of Nursing
- Marcia Hobbs, Member Board Member, Kentucky Board of Nursing
- Randall Hudspeth, Member Board Member, Idaho Board of Nursing
- Cristiana Rosa, Member Board Member, Rhode Island Board of Nurse

- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont
- Cathy Williamson, Member Board Member, Mississippi Board of Nursing
- Ann Forbes, Member Board Staff, North Carolina Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Sheila N. Kaiser, Member Board Vice-Chair, Massachusetts Board of Registration in Nursing
- Nancy Chornick, NCSBN

2007

- Faith Fields, Board Liaison Arkansas State Board of Nursing
- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Ann L. O'Sullivan, Board Member, Pennsylvania Board of Nursing
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Laura Poe, Member Utah State Board of Nursing
- John C. Preston, Board Member, Tennessee Board of Nursing
- Randall Hudspeth, Member Board Member, Idaho Board of Nursing
- Cristiana Rosa, Member Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont
- Cathy Williamson, Member Board Member, Mississippi Board of Nursing
- Janet Younger, Board President, Virginia Board of Nursing
- Marcia Hobbs, Member Board Member, Kentucky Board of Nursing
- Nancy Chornick, NCSBN

2008

- Doreen K. Begley, Board Representative, Member Board Member, Nevada State Board of Nursing
- Ann L. O'Sullivan, Board Member, Pennsylvania Board of Nursing
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Laura Poe, Member Utah State Board of Nursing
- John C. Preston, Board Member, Tennessee Board of Nursing
- Randall Hudspeth, Member Board Member, Idaho Board of Nursing
- Cristiana Rosa, Member Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont
- Cathy Williamson, Member Board Member, Mississippi Board of Nursing
- Tracy Klein, Member Staff, Oregon State Board of Nursing
- Darlene Byrd, Member Board Member, Arkansas State Board of Nursing
- Nancy Chornick, NCSBN

Appendix D

2006 NCSBN APRN Roundtable
Organization Attendance List

Alabama Board of Nursing
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners National Certification Program, Inc
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American Association of Psychiatric Nurses
American Board of Nursing Specialties
American College of Nurse Practitioners
American College of Nurse-Midwives
American Holistic Nurses' Certification Corporation
American Midwifery Certification Board
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurses Executives
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Council on Accreditation of Nurse Anesthesia Educational Programs
Emergency Nurses Association
George Washington School of Medicine
Idaho Board of Nursing
Kansas Board of Nursing
Kentucky Board of Nursing
Massachusetts Board of Nursing
Mississippi Board of Nursing
National Association of Clinical Nurse Specialists
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Board for Certification of Hospice & Palliative Nurses
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties
National League for Nursing Accrediting Commission
North Carolina Board of Nursing
Oncology Nursing Certification Corporation
Pediatric Nursing Certification Board
Rhode Island Board of Nursing

NAPNAP
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
NCC
Oncology Nursing Certification Corporation
Pennsylvania Board of Nursing
PNCB
Rhode Island Board of Nursing
Rush University College of Nursing
South Dakota Board of Nursing
Tennessee Board of Nursing
Texas Board of Nurse Examiners
Vermont Board of Nursing

APPENDIX E

APRN Joint Dialogue Group
Organizations represented at the Joint Dialogue Group Meetings

American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American Nurses Association
American Organization of Nurse Executives
Compact Administrators
National Association of Clinical Nurse Specialists
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
National Council of State Boards of Nursing
NCSBN APRN Advisory Committee Representatives (5)

Appendix F

ORGANIZATIONS INVITED TO APN CONSENSUS CONFERENCE JUNE, 2004

American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Academy of Nursing
American Association of Critical Care Nurses
American Association of Critical Care Nurses Certification Program
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American Board of Nursing Specialties
American College of Nurse Practitioners
American College of Nurse-Midwives
American College of Nurse-Midwives Division of Accreditation
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
Association of Faculties of Pediatric Nurse Practitioners
Association of Rehabilitation Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
Certification Board Perioperative Nursing
Commission on Collegiate Nursing Education
Council on Accreditation of Nurse Anesthesia Educational Programs
Division of Nursing, DHHS, HRSA
Emergency Nurses Association
Hospice and Palliative Nurses Association
International Nurses Society on Addictions
International Society of Psychiatric-Mental Health Nurses
NANDA International
National Association of Clinical Nurse Specialists
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Nurse Practitioners in Women's Health, Council on Accreditation
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Board for Certification of Hospice and Palliative Nurses
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National Gerontological Nursing Association
National League for Nursing
National League for Nursing Accrediting Commission

National Organization of Nurse Practitioner Faculties
Nurse Licensure Compact Administrators/State of Utah Department of Commerce/Division of Occupational & Professional Licensing
Nurses Organization of Veterans Affairs
Oncology Nursing Certification Corporation
Oncology Nursing Society
Pediatric Nursing Certification Board
Sigma Theta Tau, International
Society of Pediatric Nurses
Wound Ostomy & Continence Nurses Society
Wound Ostomy Continence Nursing Certification Board

APPENDIX G

ORGANIZATIONS PARTICIPATING IN APRN CONSENSUS PROCESS

Academy of Medical-Surgical Nurses
American College of Nurse-midwives Division of Accreditation
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Critical Care Nurses Certification
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American Board for Occupational Health Nurses
American Board of Nursing Specialties
American College of Nurse-Midwives
American College of Nurse-Midwives Division of Accreditation
American College of Nurse Practitioners
American Holistic Nurses Association
American Nephrology Nurses Association
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
American Society of PeriAnesthesia Nurses
American Society for Pain Management Nursing
Association of Community Health Nursing Educators
Association of Faculties of Pediatric Nurse Practitioners
Association of Nurses in AIDS Care
Association of PeriOperative Registered Nurses
Association of Rehabilitation Nurses
Association of State and Territorial Directors of nursing
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Council on Accreditation of Nurse Anesthesia Educational Programs
Commission on Collegiate Nursing Education
Commission on Graduates of Foreign Nursing Schools
District of Columbia Board of Nursing
Department of Health
Dermatology Nurses Association
Division of Nursing, DHHS, HRSA
Emergency Nurses Association
George Washington University
Health Resources and Services Administration
Infusion Nurses Society
International Nurses Society on Addictions

International Society of Psychiatric-Mental Health Nurses
Kentucky Board of Nursing
National Association of Clinical Nurse Specialists
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health, Council on Accreditation
National Association of Pediatric Nurse Practitioners
National Association of School of Nurses
National Association of Orthopedic Nurses
National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National League for Nursing
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
Nephrology Nursing Certification Commission
North American Nursing Diagnosis Association International
Nurses Organization of Veterans Affairs
Oncology Nursing Certification Corporation
Oncology Nursing Society
Pediatric Nursing Certification Board
Pennsylvania State Board of Nursing
Public Health Nursing Section of the American Public Health Association.
Rehabilitation Nursing Certification Board
Society for Vascular Nursing
Texas Nurses Association
Texas State Board of Nursing
Utah State Board of Nursing
Women's Health, Obstetric & Neonatal Nurses
Wound, Ostomy, & Continence Nurses Society
Wound, Ostomy, & Continence Nursing Certification

APPENDIX H

APRN CONSENSUS PROCESS WORK GROUP

ORGANIZATIONS THAT WERE REPRESENTED AT THE WORK GROUP MEETINGS

Jan Towers, American Academy of Nurse Practitioners Certification Program
Joan Stanley, American Association of Colleges of Nursing
Carol Hartigan, American Association of Critical Care Nurses Certification Corporation
Leo LeBel, American Association of Nurse Anesthetists
Bonnie Niebuhr, American Board of Nursing Specialties
Peter Johnson & Elaine Germano, American College of Nurse-Midwives
Mary Jean Schumann, American Nurses Association
Mary Smolenski, American Nurses Credentialing Center
M.T. Meadows, American Organization of Nurse Executives
Edna Hamera & Sandra Talley, American Psychiatric Nurses Association
Elizabeth Hawkins-Walsh, Association of Faculties of Pediatric Nurse Practitioners
Jennifer Butlin, Commission on Collegiate Nursing Education
Laura Poe, APRN Compact Administrators
Betty Horton, Council on Accreditation of Nurse Anesthesia Educational Programs
Kelly Goudreau, National Association of Clinical Nurse Specialists
Fran Way, National Association of Nurse Practitioners in Women's Health, Council on Accreditation
Mimi Bennett, National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties
Kathy Apple, National Council of State Boards of Nursing
Grace Newsome & Sharon Tanner, National League for Nursing Accrediting Commission
Kitty Werner & Ann O'Sullivan, National Organization of Nurse Practitioner Faculties
Cyndi Miller-Murphy, Oncology Nursing Certification Corporation
Janet Wyatt, Pediatric Nursing Certification Board
Carol Calianno, Wound, Ostomy and Continence Nursing Certification Board
Irene Sandvold, DHHS, HRSA, Division of Nursing *(observer)*

ADDENDUM

Example of a National Consensus-Building Process to Develop Nationally Recognized Education Standards and Role/Specialty Competencies

The national consensus-based process described here was originally designed, with funding by the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, to develop and validate national consensus-based primary care nurse practitioner competencies in five specialty areas. The process was developed with consultation from a nationally recognized expert in higher education assessment. The process subsequently has been used and validated for the development of similar sets of competencies for other areas of nursing practice, including competencies for mass casualty education for all nurses and competencies for acute care nurse practitioners and psych/mental health nurse practitioners.

This process for developing nationally recognized educational standards, nationally recognized role competencies and nationally recognized specialty competencies is an iterative, step-wise process. The steps are:
Step 1: At the request of the organization(s) representing the role or specialty, a neutral group or groups convenes and facilitates a national panel of all stakeholder organizations as defined in step 2.
Step 2: To ensure broad representation, invitations to participate should be extended to one representative of each of the recognized nursing accrediting organizations, certifiers within the role and specialty, groups whose primary mission is graduate education and who have established educational criteria for the identified role and specialty, and groups with competencies and standards for education programs that prepare individuals in the role and specialty.
Step 3: Organizational representatives serving on the national consensus panel bring and share role delineation studies, competencies for practice and education, scopes and standards of practice, and standards for education programs.
Step 4: Agreement is reached among the panel members
Step 5: Panel members take the draft to their individual boards for feedback.
Step 6: That feedback is returned to the panel. This is an iterative process until agreement is reached.
Step 7: Validation is sought from a larger group of stakeholders including organizations and individuals. This is known as the Validation Panel.
Step 8: Feedback from the Validation Panel is returned to National Panel to prepare the final document.
Step 9: Final document is sent to boards represented on the National Panel and the Validation Panel for endorsement.

The final document demonstrates national consensus through consideration of broad input from key stakeholders. The document is then widely disseminated.

BOARD OF REGISTERED NURSING

NURSING PRACTICE COMMITTEE

AGENDA ITEM SUMMARY

AGENDA ITEM: 3.0
DATE: August 21, 2008

ACTION REQUESTED: Information only: American Nurses Association Endorse Consensus Model for APRN Regulations: Licensure, Accreditation, Certification, & Education

REQUESTED BY: Janette Wackerly, MBA, RN
Nursing Education Consultant

BACKGROUND:
The American Nurses Association news release July 1, 2008 ANA Board of Directors endorses a set of standards for APRN regulation to improve access to safe, quality care by advanced practice nurses.

ANA President Rebecca M. Patton, MSN, RN, CNOR statement is that *"A Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, & Education"* will, for the first time, when implemented, standardize each aspect of the regulatory process for APRNs, resulting in increased mobility, and will establish independent practice as the norm rather than the exception. This will support APRNs caring for patients in a safe environment to the full potential of their nursing knowledge and skill.

ANA states that the APRN community is comprised of four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), certified clinical nurse specialist (CNS), and certified nurse practitioner (CNP). Additionally, APRN's focus on at least one of six population foci: psych/mental health, women's health, adult-gerontology, pediatrics, neonatal, or family.

American Nurses Association, News Release 7/1/2008

NEXT STEP: Place on Board Agenda

FISCAL IMPLICATIONS, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, MBA, RN
Nursing Education Consultant
(916) 574-7686

American Nurses Association
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Silver Spring, Maryland 20910-3492
Tel (301) 628-5000
Fax (301) 628-5001
www.NursingWorld.org

NEWS RELEASE

AMERICAN NURSES ASSOCIATION

FOR IMMEDIATE RELEASE
July 1, 2008

CONTACT: **Mary McNamara, 301-628-5198**
mary.mcnamara@ana.org
Mary Stewart, 301-628-5038
mary.stewart@ana.org
www.nursingworld.org

ANA BOARD OF DIRECTORS ENDORSES A SET OF STANDARDS FOR APRN REGULATION TO IMPROVE ACCESS TO SAFE, QUALITY CARE BY ADVANCED PRACTICE NURSES

SILVER SPRING, MD – At its June Board meeting in Washington, DC., the American Nurses Association (ANA) Board of Directors endorsed a seminal document beneficial not only to the 240,000 Advanced Practice Registered Nurses (APRNs) in the United States, but to the entire nursing profession and to the public they serve.

"A *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education will*, for the first time, when implemented, standardize each aspect of the regulatory process for APRNs, resulting in increased mobility, and will establish independent practice as the norm rather than the exception. This will support APRNs caring for patients in a safe environment to the full potential of their nursing knowledge and skill." said ANA President Rebecca M. Patton, MSN, RN, CNOR.

The APRNs community is comprised of four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), certified clinical nurse specialist (CNS), and certified nurse practitioner (CNP). Additionally, APRNs focus on at least one of six population foci: psych/mental health, women's health, adult-gerontology, pediatrics, neonatal, or family.

Substantial challenges to educational expectations and certification requirements for APRNs, and the proliferation of nursing specializations have sparked debates on appropriate credentials, scope of practice, and state-by-state regulation of nursing scope of practice. To that end, the consensus model for APRN regulation focuses on the regulation and credentialing of nurses.

MORE

All graduate level APRN education will be required to include a broad-based education in the role, and in the population to be served, and will, in addition, include three separate graduate-level courses in advanced pathophysiology, advanced health assessment and advanced pharmacology as well as a minimum of 500 hours of appropriate clinical experiences. As a result of implementation of the new model, all developing graduate level APRN education programs or tracks will go through a pre-approval, pre-accreditation or accreditation process prior to admitting any students to that program or track. APRN educational programs must be housed within graduate programs that are nationally accredited and they must ensure that their programs adequately prepare their graduates to meet eligibility for national certification which leads to state licensure.

The "*Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education*," was developed by members of the APRN Consensus Work Group, facilitated by American Association of Colleges of Nursing and the National Council of State Boards of Nursing (NCSBN) APRN Advisory Committee during four years of discussions and collaborative efforts in this groundbreaking effort to create a unified vision; this vision which defines APRN roles, practice and populations served. The goal is for full implementation of the new model by 2015.

The American Nurses Association (ANA) has been an active participant in both the APRN Consensus Work Group and the subsequently formed Joint Dialogue Group. In addition to ANA, members of the Joint Dialogue Group are the: American Academy of Nurse Practitioners Certification Program, National Association of Clinical Nurse Specialists, American Association of Colleges of Nursing, American Association of Nurse Anesthetists, American College of Nurse-Midwives, American Organization of Nurse Executives, National Organization of Nurse Practitioner Faculties, National Council of State Boards of Nursing, National Council of State Boards of Nursing APRN Advisory Committee, National League for Nursing Accrediting Commission and nursing compact administrators.

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BOARD OF REGISTERED NURSING

NURSING PRACTICE COMMITTEE

AGENDA ITEM SUMMARY

AGENDA ITEM: 4.0
DATE: August 21, 2008

ACTION REQUESTED: Topic: Geriatric Nursing Practice and Education: Issues and Resources

By: Ann M. Mayo; RN; DNSc
Hartford Post Doctoral Fellow

REQUESTED BY: Janette Wackerly, MBA, RN
Nursing Education Consultant

BACKGROUND:
Gerontological and geriatric nursing practice and educational issues will be presented and discussed. Topics will include aging, health care delivery to older adults across settings, and diversity as it impacts care to older adults. Resources for faculty development, curriculum development, and certification will be introduced.

Building Academic Nursing Capacity: http://www.geriatricnursing.org/

Hartford Geriatric Nursing Competencies:
http://www.hartfordign.org/resources/education/competencies.pdf

American Nursing Credentialing Center (ANCC): http://www.nursecredentialing.org/#

John A. Hartford RN Review Course: http://www.nyu.edu/nursing/ce/gncrc/

NEXT STEP: Place on Board Agenda

FISCAL IMPLICATIONS, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, MBA, RN
Nursing Education Consultant
(916) 574-7686

The John A. Hartford Foundation Institute for Geriatric Nursing

HGNI Hartford Geriatric Nursing Initiative

Who are you?
Practicing Nurse
Staff Development Educator
Nurse Administrator
Nurse Manager
Nursing Faculty
Nursing Student
Policy Maker
Nursing Association
Press

Highlights
Try This Series
How To Try This Series
Evidence-Based Protocols - ConsultGeriRN.org
NICHE Hospital Program
Fundamental Geriatric Resources
Gerontological Nursing Certification Review Course
Scholars Research Seminar
Special Topics in Long Term Care
Awards

WELCOME!

Improving health care of older adults through nursing.

Older adults are now the core business of health care. We are pleased that you recognize the importance of nursing's role in providing older adults with high quality care.

Hartford Institute eNewsletter

The Hartford Institute eNewsletter features articles, reference materials, useful links, calendar of events and other best practice information on the care of older adults. Visit the eNews page to learn more about the eNewsletter, view an archive of past eNewsletters, or to sign up to receive the eNewsletter on a monthly basis. Learn More...

Geriatric Nursing Research Summer Scholars Program
July 14 – July 18, 2008

How To try this

ASSESSING OLDER ADULTS
COST-FREE WEB-BASED RESOURCES

ConsultGeriRN.org - Evidence-based clinical website on care of older adults.

NEW! 2008 AACN/Hartford Institute Geriatric Education Awards. Applications du May 1, 2008.

NEW! How to *Try This!* Assessing Older Adults Cost-Free Web-Based Resources

NEW! *Geriatric Nursing* Publishes Special Issue Specialty Nursing Association Efforts and Achievements

Geriatrics and the Advanced Practice Curriculum Web-Based Interactive Case Studies

Enhance geriatric conte in senior-level undergraduate nursing courses

THE JOHN A. HARTFORD FOUNDATION
INSTITUTE FOR GERIATRIC NURSING

Competency: Care of Adult 65 years +

Method of Evaluation Key:
Knowledge: **T**-Test/Self Learning Module, **S**-Simulation/Scenario, **V**-Verbalizes Understanding
Skills and Behavior: **O**-Direct Observation, **MR**-Medical Record Audit, **RD**-Return Demonstration, **NA**=Not Applicable

COMPETENCIES	Self Evaluation By Employee			Validation of Competency	
	No Prior Experience	Needs to Review	Can Perform	Date Preceptor/Evaluator Signature Print Name	Evaluation Method (See Key Above)
1. COMMUNICATION: For older adults, demonstrate knowledge, skills and behavior of best practices in order to:					
Use communication strategies to meet patients' needs					
Assure participation in decision making: advance directives, health care proxy, DNR, informed consent					
Assess barriers (drug interactions, dementia, delirium, disease states, depression) that impact patients' understanding of information, following directions and making needs known					
Demonstrate familiarity w/adaptive devices (hearing aid, listenator)					
2. PHYSIOLOGICAL AND PSYCHOLOGICAL AGE CHANGES: For older adults, demonstrate knowledge, skills and behavior of best practices in order to:					
Intervene to address changes in temperature, BUN and creatinine					
Assess cognitive status for delirium,dementia and/or depression. Use standardized scale to assess:					
Mental Status (e.g., Mini Mental Status Examination - MMSE)					
Delirium (e.g., Confusion Assessment Method - CAM)					

Competency: Care of Adult 65 years +

Method of Evaluation Key:
Knowledge: **T**-Test/Self Learning Module, **S**-Simulation/Scenario, **V**-Verbalizes Understanding
Skills and Behavior: **O**-Direct Observation, **MR**-Medical Record Audit, **RD**-Return Demonstration, **NA**=Not Applicable

COMPETENCIES	Self Evaluation By Employee			Validation of Competency	
	No Prior Experience	Needs to Review	Can Perform	Date Preceptor/Evaluator Signature Print Name	Evaluation Method (See Key Above)
Depression (e.g., Geriatric Depression Scale - GDS)					
Use organization's established criteria for management of polypharmacy					
Intervene to eliminate or sharply curtail adverse events associated with medications, diagnostic or therapeutic procedures, nosocomial infections or environmental stressors					
3. <u>PAIN:</u> For older adults, demonstrate knowledge, skills and behavior of best practices in order to:					
Assess pain in cognitively impaired patients using valid and reliable self-report instruments and/or observations of patient behaviors (agitation, withdrawal, vocalizations, facial response/grimaces) *****					
Intervene for the cognitively impaired when assessment is inconclusive and pain is to be expected					
***** assessment & management of pain in cognitively intact older patients is no different than all patients					
4. <u>SKIN INTEGRITY:</u> For older adults, demonstrate knowledge, skills and behavior of best practices in order to:					
Assess the risk of skin breakdown using a standardized scale (e.g., Braden Scale)					
Use organization's established criteria to implement appropriate bathing, choice of skin products, and positioning					

Competency: Care of Adult 65 years +

Method of Evaluation Key:
Knowledge: **T**-Test/Self Learning Module, **S**-Simulation/Scenario, **V**-Verbalizes Understanding
Skills and Behavior: **O**-Direct Observation, **MR**-Medical Record Audit, **RD**-Return Demonstration, **NA**=Not Applicable

COMPETENCIES	Self Evaluation By Employee			Validation of Competency	
	No Prior Experience	Needs to Review	Can Perform	Date Preceptor/Evaluator Signature Print Name	Evaluation Method (See Key Above)
5. FUNCTIONAL STATUS: For older adults, demonstrate knowledge, skills and behavior of best practices in order to:					
Overall function:					
Demonstrates within care plan appropiate intervention to promote function in response to change in activities of daily living(ADL) and instrumental activities of daily living(IADL)					
Use assistive devices and suggest or initiate referral to appropriate therapies (OT, PT, ST) to promote and maintain optimal function					
Urinary incontinence:					
Identify and refer to appropiate clinican recent onset of urinary incontinence (UI)					
Document rational for use of indwelling catheters other than in specified clinical situations(e.g., stage III/IV pressure ulcers, monitored acutely ill patients, urinary retention not manageable by other means)					
Nutrition/Hydration:					
Use organization's established criteria to identify high risk patients for nutritional/fluid deficit					
Intervene to address barriers to nutritional/fluid adequacy (e.g., difficulty with chewing & swallowing, alterations in hunger and thirst, inability to self feed & capacity of others to feed)					
Falls and injuries:					
Use a valid and reliable measure of fall risk assessment					
Use the organization's established falls prevention protocol					

Competency: Care of Adult 65 years +

Method of Evaluation Key:
Knowledge: **T**-Test/Self Learning Module, **S**-Simulation/Scenario, **V**-Verbalizes Understanding
Skills and Behavior: **O**-Direct Observation, **MR**-Medical Record Audit, **RD**-Return Demonstration, **NA**=Not Applicable

COMPETENCIES	Self Evaluation By Employee			Validation of Competency	
	No Prior Experience	Needs to Review	Can Perform	Date Preceptor/Evaluator Signature Print Name	Evaluation Method (See Key Above)
6. <u>RESTRAINTS:</u> For older adults, demonstrate knowledge, skills and behavior of best practices in order to:					
Document discussion of the use of a physical restraint(Posey, mitts, chairs with fixed trays, sheets, side rails)					
Document behavior of patient who is physically restrained					
Intervene to eliminate or sharply curtail the use of physical restraints (e.g. alternate strategies to prevent falls, to prevent treatment interference, and to manage agitated and/or combative behavior)					
7. <u>ELDER ABUSE:</u> For older adults, demonstrate knowledge, skills and behavior of best practices in order to:					
Use organization's established criteria to identify elder abuse					
8. <u>DISCHARGE PLANNING:</u> For older adults, demonstrate knowledge, skills and behavior of best practices in order to:					
Transmit timely and complete information to patient/family, home care/ skilled nursing facility (e.g. minimal data elements include diagnoses and medications, including dose & last dose taken)					
Provide patient education materials that are legible, printed clearly and at appropriate level of medical literacy					
Refer for evaluation of the need for special resources for transition to home (e.g.:Meals on Wheels, adaptive devices, etc.)					

Competency: Care of Adult 65 years +

Method of Evaluation Key:
Knowledge: **T**-Test/Self Learning Module, **S**-Simulation/Scenario, **V**-Verbalizes Understanding
Skills and Behavior: **O**-Direct Observation, **MR**-Medical Record Audit, **RD**-Return Demonstration, **NA**=Not Applicable

COMPETENCIES	Self Evaluation By Employee			Validation of Competency	
	No Prior Experience	Needs to Review	Can Perform	Date Preceptor/Evaluator Signature Print Name	Evaluation Method (See Key Above)

The John A. Hartford Foundation For Geriatric Nursing
New York University, The Steinhardt School of Education, Division of Nursing
246 Greene Street, 6th floor, New York, NY 10003
tel:212-998-9018 fax:212-995-4770 email:hartford.ign@nyu.edu
web site:http://www.hartfordign.org

Geriatric and Gerontological Nursing Resources

Ann M. Mayo, RN; DNSc

August 21, 2008

AACN Geriatric Core Competencies. http://www.aacn.nche.edu/Education/gercomp.htm

American Geriatrics Foundation for Health in Aging. http://www.healthinaging.org/aginginthеknow/

American Geriatrics Society. *http://www.americangeriatrics.org/*

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Birks, J. (2006). Cholinesterase inhibitors for Alzheimer's disease. The Cochrane database of systematic reviews, (1), CD005593-.

Britton, A, & Russell, R. (2006). WITHDRAWN: Multidisciplinary team interventions for delirium in patients with chronic cognitive impairment. The Cochrane database of systematic reviews, (2), CD000395-.

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Charlson, ME, Peterson, JC, Syat, BL, et al. (2008). Outcomes of community-based social service interventions in homebound elders. International journal of geriatric psychiatry, 23(4), 427-32.

Cotter, V. T., Evans, L. K. (2007). Try this: Best practices in nursing care for hospitalized older adults. D1. www.hartfordign.org

Delirium Prevention Program. http://elderlife.med.yale.edu/public/doclinks.php?pageid=01.02.03

de Morton, NA, Keating, JL, & Jeffs, K. (2007). Exercise for acutely hospitalised older medical patients. The Cochrane database of systematic reviews, (1), CD005955-.

Flaherty, JH, McBride, M, Marzouk, S, et al. (1998). Decreasing hospitalization rates for older home care patients with symptoms of depression. Journal of the American Geriatrics Society, 46(1), 31-8.

Gerontological Society of America. *http://www.geron.org/*

Greenberg, SA. (2007). How To try this: The Geriatric Depression Scale: Short Form. The American journal of nursing, 107(10), 60-69.

Hall, CB, Derby, C, LeValley, A, et al. (2007). Education delays accelerated decline on a memory test in persons who develop dementia. Neurology, 69(17), 1657-64.

HRSA Comprehensive Geriatric Education Program
https://grants.hrsa.gov/webexternal/FundingOppDetails.asp?FundingCycleId=E788108A-E00D-4210-B70C-8B84184BBD66&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=True&pageNumber=1

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Henry, J. D. & Henry, L. G. (2007). *Transformational Eldercare from the Inside Out: Strengths-based strategies for caring.* Silver Spring, MD: American Nurses Association.

Hermans, DG, Htay, UH, & McShane, R. (2007). Non-pharmacological interventions for wandering of people with dementia in the domestic setting. The Cochrane database of systematic reviews, (1), CD005994-.

Hill, KD, Vu, M, & Walsh, W. (2007). Falls in the acute hospital setting--impact on resource utilisation. Australian health review, 31(3), 471-7.

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Inouye, SK, Baker, DI, Fugal, P, et al. (2006). Dissemination of the hospital elder life program: implementation, adaptation, and successes. Journal of the American Geriatrics Society, 54(10), 1492-9.

John A. Hartford Funded Initiatives
Building Academic Geriatric Nursing Capacity (BAGNC).
http://www.geriatricnursing.org/

Creating Careers in Geriatric Advanced Practice Nursing.
www.aacn.nche.edu/Education/Hartford/enhancing.htm

Enhancing Geriatric Nursing Education for Baccalaureate and Advanced Practice Nursing. www.aacn.nche.edu/Education/Hartford/enhancing.htm

Enhancing Gerontology Content in Baccalaureate Nursing Education Programs. www.aacn.nche.edu/GNEC.htm

Geriatric Nursing Education Consortium. www.aacn.nche.edu/geroapp/

Nursing School Geriatric Investment Program. www.geriatricnursing.org/nsgip

Sigma Theta Tau Leadership Program. http://www.nursingsociety.org/LeadershipInstitute/GeriatricAcademy/

Try This Series. http://www.hartfordign.org/resources/education/tryThis.html

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